

Registered First Level Mental Health Nurses Discourse Analytic
Construction of their Professional Identity

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I certify that this thesis is the true and accurate version of the thesis
approved by the examiners.

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21/05/03

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This work is dedicated to my children Nicola and Christopher

Abstract

Mental Health Nursing exists as a discipline within the contemporary health care establishment. Throughout its history it has attempted to define itself in ways that differentiate mental health nursing practice from other health care professions and fields of nursing. It is not surprising in the climate of contemporary healthcare delivery for individual professional identities to become lost in the melange of interdisciplinary education and practice. This study is concerned with researching mental health nurses' identities. In so doing, it adopts a social constructionist, discourse analytic approach to explore individual mental health nurses' 'identity constructions' as they emerge in their talk with each other in focus group discussions. The aim of the research is to illustrate how identities are rhetorically constructed in the justifications, accounts and explanations of what mental health nurses do every day. Thus the stance is taken that identity constructions are not things that are hidden inside the individual, which can then be 'discovered'. Rather they are the accomplishment of action created in the language used to describe them. The research begins from a commonly understood contextual premise. It then moves to explore the application of a social constructionist, discourse analytic approach in researching mental health nurse identities. In this way the 'functionality' of language is emphasised. Thus, this research proposes that there is a natural synergy between the social constructionist, discourse analytic approach and the ways in which mental health nursing is practised. It is further proposed that mental health nurse identity is socially constructed and negotiated through talk. Extracts from the corpus of transcribed data generated from focus group discussions with registered first level mental health nurses were subject to in depth discourse analysis. The rhetorical 'identity constructions' yielded under analysis in this research are wide ranging, complex and dynamic. Insights generated from this research have implications for mental health nursing practice, education and in the strategic implementation of policy. Finally, this research serves as a 'voice' that assists in articulating mental health nursing as the bedrock of experience by the participants in this study. In so doing it is both emancipatory and empowering,

placing mental health nursing within a particular position within the complex world of health care practice.

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Chapter 1: The Thesis

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- 1.2 Aims of the Study
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1.1 Introduction

This introductory chapter serves to provide an overview of the research study. It is presented in three discrete albeit related sections that collectively identify the nature, purpose, structure and implications of this study.

Tierney (1996 p.374), in discussing reporting and disseminating research, suggests that the introductory part of a research project “needs to be especially clear and engaging if the reader is to be persuaded to venture further”. To this end, this chapter has been constructed to make explicit the research aims and background. The research aims illustrate what has been achieved at each phase in the process, and locates the methodological focus of the research. In the background section, the rationale for this research embraces three key perspectives that premise the study. This is followed by an overview of the structure and the development of a conceptual framework for the research, as a means of situating the author’s thinking, coupled with providing an overview of the logical flow and content of the chapters that constitute this thesis. Cormack (1984, p.40) cautions that the interrelationships of the various phases of research are many and complex. In this research they serve to present this researcher’s construction of this research process.

As with any other research project, a salient feature lies in stating clearly defined aims. The following section of this chapter illustrates these.

1.2 Aims of the study

The main aim of this research is the exploration of registered first level mental health nurse participants' constructions of their professional identity. To this end this research has sought to:

- Review a range of literature that provides contextual orientation for the research
- Explore and apply a social constructionist, researcher reflexive, discourse analytic approach to this research
- Discuss the use of the methodological approach adopted in this research in relation to its contribution to mental health nursing research, practice, education and policy
- Identify and discuss wider considerations that have arisen from this research

These aims have guided the development of this study and were visited and re-visited continually throughout the research process in order to remain focused. In the discussions that follow, the rationale and background to this study are made explicit. These have been developed from a three-fold perspective that includes personal interest, the importance of this research from a professional perspective and the contribution that this study will make to the growing interest in 'identity research'. The researcher's initial thinking in relation to this research is presented in the following small section and elaborated in the following sections in this chapter.

1.3 Background to the study

A central tenet in the adoption of a social constructionist, discourse analytic approach to this research lies in positioning the researcher reflexively within the study. Cormack (1996, p.55) proposes that as a researcher one should reflectively “turn to your own experience. How often have you questioned, either in your mind or with your colleagues, a situation...wondering how you can improve it”. The researcher’s reflexive engagement in this study is covered in more detail in chapter three of this thesis. However, the notion of ‘questioning in one’s mind’ certainly was the starting point for this work. The following discussions serve at this point however to make explicit the researcher’s personal interest in this study.

1.3.1 Personal Perspective

As a mental health practitioner and senior lecturer in nursing in higher education, a natural professional interest in both the topic of investigation and its contextual orientations exists in the every day life of the researcher. As with other mental health researchers, interest in a discipline that has a long, complex and colourful history is easy to sustain. As an academic and a nurse, this researcher engages with individuals across a wide spectrum. This includes individuals engaged in initial preparation for their chosen career. It also encompasses those in the process of continued professional development, as experienced practitioners seeking to move forward in a complicated and competitive employment world. It is in this engagement with these ‘student’

populations that this research originated. There are guidelines and dictates that refer to the nature and content of educational programmes (UKCC, 1987, NBS, 1987). These have been designed to prepare neophyte mental health nurses for entry to their chosen part of the professional register and beyond. However, some mental health nurses remain confused and frustrated when trying to position themselves discursively within the world of nursing and health care. Indeed, in conversation with student nurses following early mental health clinical placements, when asked what they did in their practice areas, responses such as “not much really” and “just talking to patients” were commonplace. Some rationale for this is presented by Michael (1994, p.57) who discusses the problems of understanding mental health nursing by those not familiar with the ‘invisible skills’ of the discipline. He strongly suggests that the challenges that mental health nurses face fall into two key categories. He cites these as being “to recognise the value of core activities, and secondly, to succeed in articulating this to others who are unfamiliar with our work” (Michael 1994, p.57). A similar struggle exists with experienced mental health nurses in making clear their new and advancing roles within this discipline. As such, it became apparent that by researching mental health nurses’ ‘talk’ in a group setting and in analysing the commonly used discursive devices in their ‘talk’, these nurses were indeed ‘constructing their identities’ rhetorically. This was how the personal interest in this study began.

However, there is another element to this personal reflective stance. This study also serves to meet the researcher’s personal and professional goal.

In undertaking this work at Doctoral level, the award of PhD realises a career ambition for the researcher.

Having identified personal interests, the following discussions are concerned with the rationale for this researcher from a professional perspective.

1.3.2 Professional Perspective

Doctoral research has a particular purpose required by the Higher Education Funding Council (HEQC, 1996). This purpose is generally stated within the guidelines for higher awards of the supporting institution. In this case The University of Abertay Dundee (1999, p.1-1, 3.1.4) states that

“The degree of doctor of philosophy (PhD) or doctor of business administration (DBA) shall be awarded to a research degree student who, having critically investigated an approved topic resulting in an independent and original contribution to knowledge and demonstrated an understanding of research methods appropriate to the chosen field, has presented and defended a thesis by oral examination to the satisfaction of the examiners”

As such this research has been developed to achieve these goals. The interpretation of ‘contribution of knowledge’, proposed in this research is the contribution this research makes to nurse identity research. The value of this is in keeping with the view presented by Gilbert (1989) who suggests that it is important to be able to identify the discursive practices through which identity is formed. Gilbert (1989) proposes that it is these discursive practices, and their associated norms and values which individuals then carry with them into their every day roles. In the case of

this research, this applies to the mental health nurse participants in this study. It is also proposed that the implications for this contribution to nurse identity research will also serve to influence nurse education and as a consequence, nursing practises. Researchers concerned with mental health nursing identity suggest that it is complex and dynamic and appears to be constructed in relation to the social, political and economic context in which mental health nursing is practised (Glenister and Tilley, 1996). Mental health nursing, like mental disorder has always presented a challenge in terms of articulation. It is an area of nursing practice that continues to be shrouded in myth and misconceptions. Lupton and McLean (1998) suggest that discourses on medicine, health, illness and disease construct realities in ways that are often taken for granted and invisible. They also propose that in clearing these muddy waters, ways of understanding issues related to health, illness and healthcare therefore, should not be viewed independently from the social contexts in which they are situated (Lupton and McLean 1998, p. 950). These phenomena are discussed in more detail in the following chapters in this research. It is proposed that this research, situated within a mental health nursing context, contributes to the current professional debate that surrounds policy related to this discipline as well as mental health nurse education and practice. Currently mental health nursing exists within the world of nursing as a discrete professional discipline. It has its own 'part' on the Professional Register, allowing practitioners licence to practice. Yet despite this, it is referred to as a 'branch' of the current undergraduate pre-registration provision in nurse education. As such, metaphorically

speaking, the 'roots' of mental health nursing, one would assume, are embedded within the notion that all nursing has a single unified theoretical, historical, practical and political premise. Thus the 'identities' of mental health nurses should, if we follow that model, appear to be subsumed within that of nursing *per se*. A position that may be challenged by many contemporary mental health practitioners who believe that the origin of their practice is either rooted in a different species or has become, a hybrid worthy of its own identity. Early perceptions of psychiatric, mental health nursing, as conceptualised by Peplau (1952) in her seminal work "Interpersonal Relations in Nursing" have provided a foundation upon which growth and development of mental health nursing could emerge. Despite criticism of Peplau's position, regarding its lack of objectivity (Gourney, 1995), it is the case, that interest in this field exists and has been revisited by many other nurse researchers over the years. The importance of making a case for identity research in mental health nursing, within a complex climate of institutional and practice restructuring, professional fusion in health care and educational reform has never been more crucial. Contemporary mental health nursing exists within a political climate that encourages multi-agency working and espouses multi-professional shared education, with current Government White Papers replete with recommendations for reform in healthcare practices and the educational preparation of its professionals (appendix iii). They present a strong case for a more rigorous approach to collaborative working practices that encourage partnership between and among health care professionals and related agencies as a means of more

effectively meeting client needs. A similar agenda is encouraged in higher education institutions that provide health care education. Much has been written about the workings and indeed the failings of a multi-disciplinary approach to health care education and practice. Reeves and Pryce (1998) identify student discrepancies in their value of multi-professional education and practice experiences. Roberts and Priest (1997) highlight that this approach to health care education has been slow, citing structural and organisational challenges as impeding this process, while Erickson et al. (1998) cite issues related to occupational cultures and ideology as key sources of tension in working collaboratively. The general views that emerge from research in this field are that the different belief systems and attitude sets of the various professions inhibit co-operation. It is appropriate therefore that mental health nurses be more confident in articulating their position or 'identities' within this melange of health care multi-professionalism. These researchers also make a case for educators to be more creative, courageous and innovative in the ways they prepare mental health nurses for their role.

Within this complex and dynamic arena, service provision is adjusting yet again to social and political change. Similarly nurse education, situated within higher education is once again in a state of flux. New and developing 'specialisms' are emerging alongside sophisticated and challenging nursing roles such as specialist and advanced practitioner, consultant nurses and modern matrons. Thus, it is proposed that this nurse 'identity' research is both timely and important from both an educational and professional position.

The previous discussions have centred on mental health nursing and nurse education context, the following proposal is that this research is also a useful contribution to research studies that are concerned with the identity of social groups.

1.3.3 Research Perspective

The final premise upon which this research is based is that it serves to contribute to the growing body of ‘identity research’ that has emerged over the years. Mental health nurses exist as a social group alongside many others. Researchers who are interested in the study of identity could be said to be subscribing to the notion that “social life is a continuous display of people’s local understandings of what is going on – and that...people accomplish such local understanding by elegantly exploiting the features of ordinary talk” Antaki and Widdicombe (1998, p.1). Thus, in undertaking this research, the ‘ordinary talk’ of the mental health nurse participants is viewed as a ‘topic that requires investigation’ (Antaki and Widdicombe 1998, p.2). In so doing this study becomes part of the genre of identity research. Interest in identity exists not only in social science research but has also exercised interest in health care research. Miller’s (1998) study explored the evolution of professional identity of osteopaths; Ramirez-Valles (1999), examined the construction of female professional identities in community health workers; and Carpenter and Platt (1997) were concerned with the professional identity of clinical social workers.

Therefore it is proposed that the background for this research stems from these three preceding premises and that in making these explicit, the researcher is making a case for this Doctoral research being a valid and

worthwhile study. It is proposed that the profession of nursing would gain from more research that concerns itself with the discrete social groups that make up what constitutes an extremely large and important workforce. It is further proposed that the identities of the particular group in this research, that is registered first level mental health nurses are discursively constructed in the language they use to discuss what it is they do in practice. It is also proposed that mental health nursing would gain from more research that allowed its participants to contribute to new ways of viewing their world and by allowing these views to be heard. Adopting a social constructionist, discourse analytic approach can assist in the achievement of this. It is also further proposed that mental health nurse education would gain from more research that sheds light on issues related to professional education and new ways of viewing mental health nurse roles. This can be achieved by embracing all research that contributes to these insights. That includes studies that are new, energetic and dynamic, such as this one. It is finally proposed that as ‘identity’ research, this study will sit alongside other research that has this topic as its focus. Having presented the case for this study, the following section of this chapter will illustrate the researcher’s construction of the thesis. It will identify briefly the chapters that constitute the thesis and the researcher’s conceptual framework that underpins the development of these chapters, which in turn reflect the aims of the study.

1.4 Structure of the Thesis

In the main, this research follows the guidelines laid down by the University of Abertay Dundee Research Degrees Committee (1999) in terms of presentation and content. The nature of the investigation may, however lead to some minor modifications to this structure. However, this does not compromise the integrity or rigour of the construction of this thesis. The composition of the thesis can be seen in the table of contents. Each chapter has been constructed as a functional unit that serves to present an account of relevant literature, research and discussions that have mental health nurse identities as their focus and the research aims as their guide. The conceptual framework presented in chapter two illustrates diagrammatically how the traditionally understood contexts and those of the methodological approach contribute to registered mental health nurse identities. It is not suggested that one exists in isolation from the other, but rather that they exist in relation to and with each other. Also, in chapter two, there is a review of literature from commonly understood perspectives, covering a range of issues that the researcher views as appropriate in a research study related to mental health nursing. Following this, chapter three presents a case for a social constructionist, discourse analytic approach and explores the concept of researcher reflexivity as it is applied to this study. Within this chapter 'identity' research is revisited with some detailed discussion of work done in this field as a means of contextually situating the research approach. Chapter four explores briefly a range of available research methods and makes a case for the particular discourse analytic approach adopted in this study.

Chapter five looks in more detail at methodological considerations, including discussions regarding reliability and validity. This is followed in chapter six, by an analysis of data generated by the mental health nurse participants in focus group discussions. In chapter seven of this work discussions that have emerged from the analysis take place. These discussions are presented in a separate chapter, but it should be noted that in many qualitative studies, the analysis and discussions are presented together. Thus in this research, the discussions chapter may be seen as an extension of the analysis. Indeed this is the position adopted by the researcher. Finally, chapter eight provides summary conclusions and discussions regarding this research, including its strengths and limitations. Included with the thesis is a range of appendices that include data transcripts, the focus group topic schedule, a list of current Government papers that have influenced both current education and health care. Also included as an appendix is an illustration of refereed research conference papers and publications that have been achieved as a result of this work as it progressed.

1.5 Conclusion

In this introductory chapter, the nature and scope of this research has been outlined. The aims of the research have been clearly stated and the implications of this study in terms of its theoretical and empirical contributions have been established. The following chapter will begin the discussions by placing this research in context, albeit this is only one

context and one that is commonly understood and, as some would say
'traditional'.

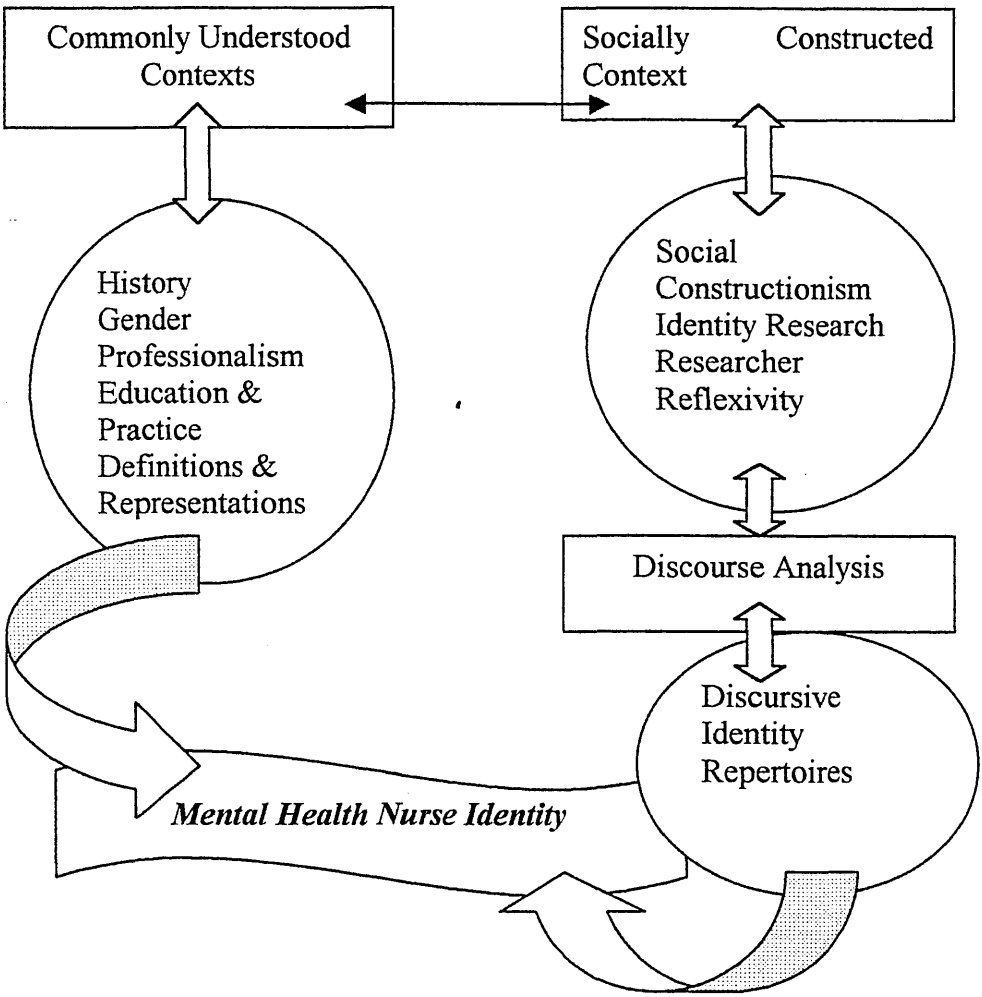
Chapter 2: Review of Relevant Literature

- 2.1 Introduction
- 2.2 Contextual Orientation
- 2.3 Historical Context
- 2.4 Nursing: Gender and Identity Context
- 2.5 Nursing: Professional Context
- 2.6 Education and Practice Context
- 2.6 Definitions, Perspectives and
 Representations
- 2.8 Conclusion

2.1 Introduction

The conceptual framework for this research is presented in Figure 1 below. This conceptual framework has been developed to illustrate the researcher's thinking in constructing and undertaking this research. Areas of relevant literature that assist in contextually situating the research topic are included in this conceptual framework. The mental health nurses' identities in this study are the result of data analyses that has adopted a social constructionist, discourse analytic approach. Albeit, the researcher acknowledges that there is an inter-relationship of various "textual commodities" (Michael 1996, p.7). In this study these include history, gender, professionalism and education and practice issues. The researcher is presenting these 'commodities' in this work as commonly understood contexts which it is proposed would traditionally be drawn upon when engaging in research related aspects of mental health nursing. The researcher also acknowledges that these are part of the individual nurse participants' discursive repertoires. As such, they exist as culturally available resources that can be used in 'talk' to achieve a particular end. In this research this is the construction of mental health nurse identities. Thus whilst in this conceptual framework, there appears to be two separate and individual contexts, it should be noted that there is a natural inter-relationship and that no one aspect of this conceptual representation exists in isolation from the other. Rather they each serve the other in a synergistic fashion to assist in presenting mental health nurse identities as complex and dynamic.

Figure 1 Conceptual Framework



The discussions that follow are designed to provide an orientation to discourses, literature and theories that relate to the identities of the mental health nurse participants in this research. The analytic thread running through this research that metaphorically ‘stitches together and binds’ the study is therefore mental health nurse identities. The ways in which we see ourselves and how others see us is an integral part of our every day lives. Similarly in nursing, ways of knowing the ‘what’ and ‘how’ of individual groups within the profession of nursing are traditionally

conceptualised through a commonly understood albeit complex amalgam of social, political and cultural practices that embrace rules, roles and behaviours. Identity research can therefore be viewed as the basis for enhancing our understanding of what it is that mental health nurses actually do as nurses. As students and neophyte nurses, individual practitioners in this field and in others have to learn to 'be' a particular type of person. That is, a mental health nurse. In so doing they are required to justify and make claims to this status throughout their careers. Thus researching mental health nurse identities is meaningful for both individual nurses and those who assist them in the process of 'becoming' mental health nurses. Dey (1993, p.32) suggests, "context in research is important as a means of situating action and grasping its wider social and historical import". As such, some detailed discussion of the settings, both past and present, in which 'actions', in this case mental health nursing and mental health nurse education, takes place are a useful starting point. Berger and Luckman (1967) remind us of the relationship between commonly understood contexts and the social constructionist position taken in this research. They propose, "because they are historical products of human activity, all socially constructed universes change, and the changes are brought about by the actions of human beings" (Berger and Luckman, 1967 p.134). As the social and political world changes, so context changes. Dey (1993, p.33) also alerts us to the concept that "since meaning can vary with context, communication can convey more than one meaning". Thus, it falls that constructions of mental health nurse identities are dynamic and in a constant state of change.

It is timely at this point to re-introduce the researcher's 'identity position' as a mental health nurse in this research, albeit this is dealt with in more detail later in discussions related to researcher reflexivity. The rationale for this overt inclusion here is that in situating this research in a given context, taking analyses and discussions forward and reaching the point of conclusion in this thesis is the researcher's 'story'. As such, like all accounts it is provisional and partial. Thus this chapter moves from commonly understood or traditional ways of viewing issues related to history, gender, nursing professionalism, education and practice to conclude with a brief discussion about the problems in attempting to neatly 'pre-package' complex phenomena. The first of these discussions explores the notion of contextually situating this research.

2.2 Contextual Orientation

The concept of 'context' will be revisited later in this work as it relates to the contextual orientation of language. At this point 'context' is presented in relation to the phenomena under investigation within this research. That is mental health nurses' identities.

The construction of social identities, according to Michael (1996, p.7), alludes to "the use of various texts - be they discourses, linguistic repertoires, rhetorics or narratives - to construct identity in given contexts". In adopting the position taken by Michael (1996, p.11), the review of literature that follows, serves to illustrate

"how representations of identity ..are mediated...and how they come to constitute individuals. The purpose here is to uncover the historical (or geneological) evolution of these representations and to probe the means by which they are imparted to, or 'inscribed upon' persons".

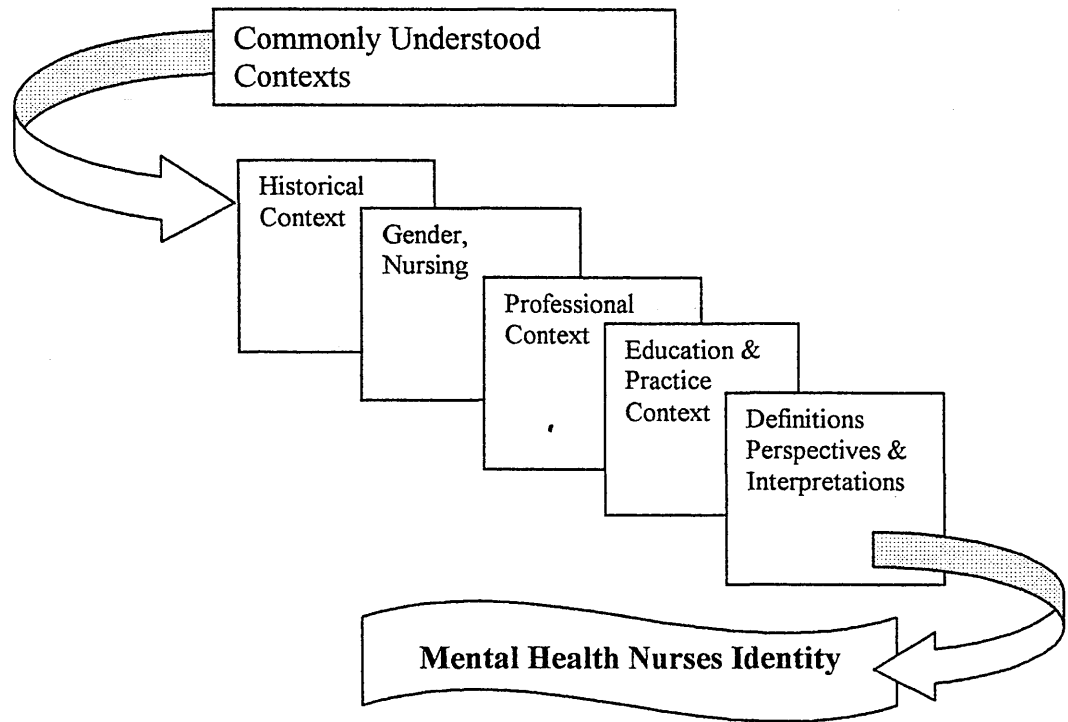
Thus, whilst this research is predominantly concerned with how mental health nurses use language as a means of constructing their identities, the literature review in itself contributes to the emergence of a range of identities of 'self'. These in turn, contribute to an insightful awareness of the identities of mental health nurses. In so doing, supporting the notion that identity is "embodied within other embodiments" (Michael 1996, p.12). Therefore it could be said that the 'commonly understood' approach has a particular synergy with the concept of mental health nursing as 'subject positions' from which mental health nurse identities are constructed.

This research is not concerned with linking the analysis in this study to 'macro social theories'. However as Bowers (1988), in his review essay of Potter and Wetherell (1987) points out "P & W self-consciously accept that DA is one approach amongst many – a distinctive one (Bowers, 1988, p.191) – and respect others with a metatheoretical liberalism". Potter and Wetherell (1987, p.7) suggest that it is possible to view the literature review aspect of academic rhetoric from the perspective of it being a "social text" which constructs a specific reality.

The review of historical issues in this chapter is not the epochal variety, or as Michael (1996, p.19) refers to it 'Big History'. Rather it is a review of historical issues that relate specifically to one social group, *viz a viz* mental health nurses. It leads to other discussions such as

professionalism, gender, education and practice. These “social texts”, as coined by Potter and Wetherell (1987, p.7) actively construct versions of the social and political world of mental health nursing. As such, in a study such as this one this lays the foundations for our understanding of mental health nurses constructions of their identities. It should also be noted that the discussions in this chapter are offered as the researcher’s own narrative of issues that are considered appropriate in orientating the reader to the research topic. In so doing, they serve to justify this research as a proper and valuable thing to do. The conceptual framework in Figure 1 is also premised on the notion that mental health nursing continues to be an evolving and complex discipline and that the professional identities of mental health nurses, as social categories, are in themselves dynamic. These can be seen in Figure 2 below.

Figure 2: Commonly Understood Contexts



Much of the reading related to the construction of research projects seem to indicate that in qualitative research, there are no hard and fast rules to the presentation of the ~~of the~~ written report. “Each thesis will look different and there is no definitive template for how to structure the main content of the study,” proposes Holloway and Walker (2000, p.134). Albeit in doctoral studies, they claim that conformity by the researcher to the guidelines offered by the supporting Institution would appear to be a wise strategy (Holloway and Walker, 2000). By and large, this study has adopted this rule. However, Porter (1996, p.332) strongly claims that the “sole dependence on data for the generation of theory...leads to a tendency for researchers to continually re-invent the wheel”. He is more

inclined towards literature that grounds researchers in the subject area they are proposing to examine. Rafferty (1996, p.5) identifies that in historical research, it is possible for the literature review to be left until the end of the project, in order that opinions and conclusions of others do not create researcher bias from the outset. She proposes that whilst not completely rejecting the positivist science paradigm, nursing knowledge may benefit from moving from an exclusively 're-search' model to one which adopts a 'future search' perspective (Rafferty, 1996, p.7). However, it is the case that in whatever way the literature review is approached, it should be an important and meaningful part of the research and not appear as a grafted on addition at either end of the study. In this work, a review of relevant literature, as viewed by the researcher, is presented in this chapter, but related literature is also referred to at appropriate junctures throughout the study. It is the case therefore, that as issues emerge in parallel to and as a result of the analytic process, relevant discussions will be presented as and when their contributions add meaningfully to the discussions. As well as reviewing literature related to history, professionalism, education and practice, this chapter also includes, a review of research that has explored issues of gender in nursing. It is not the case however that the discussions in this chapter are exhaustive. This thesis, like other doctoral research studies is undertaken over a lengthy period of time and as such some of what was available literature at the outset of the research lies historically situated in relation to currently available literature as the research thesis moves forward and finally comes to its completion. Discussions presented in the early

chapters of this work may be construed in the positivistic sense to be a 'set of taken for granted value positions' that are largely accepted as providing an appropriate orientation to the research subject under investigation in this work. These begin with discussions that have a historical orientation.

2.3 Historical Context

Barker (2000), in conversation with others, reminds us that one thing mental health nursing has to pride itself on is its history. However, he counters this with the fact that many nurses are largely ignorant of this important element. Some justification for this may lie in the fact that there has been a paucity of primary data that could shed meaningful insights into mental health nurses' past. Albeit, there is a growing renaissance in this important field, with nurse researchers recognising the importance of historical research and the value of individuals' accounts, asylum records, legal records and case notes as a means of reconstructing their past and in so doing situating contemporary nursing. Beer (1999, p.581) reminds us "social historians and clinicians have studied the history of psychiatry for many years and from many perspectives". Despite limited primary data, there appears to be sufficient sources, including asylum records, oral history accounts, legal records and case notes to produce a prolific resource for research related to this topic. Studies in this field are prolific and span a panoramic timeframe.

Walk (1961), in an analysis of the history of mental health nursing, informs us that the link between high quality nursing care and the success

of treatments and interventions was noted as early as the late 18th and early 19th centuries. Walk (1961) noted that historically the care of people with mental disorder in the United Kingdom was undertaken by religious orders with many of the carers being monks. As theories of madness shifted away from the 'spirit possession' towards a newly emerging medical model, which espoused biological and genetic theories, understanding of mental illness was, however, still in its embryonic stage. The availability of large numbers of mentally ill individuals available for study generated great enthusiasm for research and inquiry within the medical profession. This, coupled with an increase in population in Great Britain, at that time stemmed political and medical influences towards the inauguration of a National scheme of training for carers in 1891. Donnelly (1983) points out, the development of the 1845 Lunacy Acts and the introduction of the County Asylums Act (1808) have their genesis in an increasing social awareness of the 'problems' of insanity. Therefore insanity became a social problem. It is proposed that it has always been a social problem, largely guided by the beliefs of the time. Thus as Szasz's (1974) work illustrates, in the middle ages and early Renaissance periods, witchcraft and demonic possession were seen to be the causes of socially unacceptable and inexplicable behaviour, reflecting the strong social influence of religion and the Church at that time (Szasz, 1974). Although not all those who were deemed to have mental illness were killed. Some were simply regarded as 'village idiots' or 'fools', some tolerated by their communities, some kept locked away by their families and some it is

supposed, were placed in boats, the so called “ship of fools” and put to shore at distant places (Foucault, 1984).

Experiences of those who have experienced mental illness are the focus of Beveridge’s (1998) work. He scrutinised 100 patient letters, written during the active phase of their illness. Many of these letters were written to the asylum superintendent of the day Sir Thomas Coulston and present a vision of various aspects of asylum life, the regime, staff, fellow patients and their feelings. Beveridge (1998, p.461) suggests that “ a history written only with reference to the activities of physicians is seriously incomplete, as it ignores the experience of the great number of men and women who made up the asylum population”, albeit he cautions that testimonies of ‘the mad’ are not without their problems. Wright (1998) sheds light on the practice of sequential certification of insanity in England in his study of Earlswood Asylum for Children and Idiots. His database is available to other researchers with an interest in how mental health legislation and control were applied in 19th century England and Wales. While Boschma (1997) in a study of nursing care for the mentally ill in Dutch asylums in the late nineteenth to early twentieth centuries presents a picture of moral treatment with discipline, regular work and formal leisure activities being the order of the day. The experience in Holland largely mirrors the position in the UK in the same era.

Those involved in the care of individuals with mental health problems over the years have had to cope with many changes in relation to a job title that reflected their perceived role at any given time. As such, it is not difficult to conceive that determining individual professional identities

would be problematic. Nolan (1993a) reminds us that mental health nurses have experienced confusion about their own role and relates that confusion to the range of titles, which have been used to describe them. These include terms such as ‘keeper’, ‘attendant’, ‘nurse’, and ‘mental nurse’ all of which reflect the discipline’s position within a particular social and historical timeframe. From a rhetorical standpoint these titles tell their own story. Indeed Nolan (1993a, p.1200) claims “training gave them [the attendants] nothing in terms of improved pay, better conditions of service or more career opportunities to render training a step in their own professionalisation”. He views the situation at the time as an echo of Victorian nurses’ efforts to convince others of the importance of the role of the trained psychiatric nurse. However, it is interesting to note that in the 1885 Journal of Mental Science a review of the ‘Red Handbook’ which was the key training handbook of the time, states that

“we are not quite sure ourselves whether it is necessary or wise to attempt to convey instruction in physiology, etc. to ordinary attendants. Will they be better equipped for their duties for being told that the brain consists of grey and white matter and cement substance?”...We hardly see what can be gained by superficial knowledge of this kind”.

Rollin (1986, p.279)

The role of the nurse in caring for the mentally ill has always been difficult to define. Thus, the picture painted in historical accounts is largely of an uneducated but tractable workforce of attendants, whose role was routine, unrewarding and low in status (Nolan, 1993a). Historically, the intellectual climate of institutions was such that nurses were not encouraged to question the scientific principles upon which therapeutic interventions were practiced. Nor were they encouraged to seek

understanding for the daily recording of observations and data collection. Early training for asylum nurses at that time did not afford nurses their own professional identity (Chung and Nolan, 1994). “The Handbook for the Instruction of Attendants (1855)”, (Rollin 1986, p.279) identified that the first duty of the attendant was to exercise personal discipline and to impose discipline on patients by setting an example of industry, order, cleanliness and obedience. Recruitment of staff was largely based on their skills in domestic work and sports. The Handbook for the Instruction of Attendants (1853) was a milestone in the history of the development of mental health nurse education. The knowledge base for nursing at that time was largely medical model orientated. This development oppressed nurses and reinforced the omnipotence of medical knowledge in the treatment and care of the mentally ill. However, the climate changed with the introduction of the “Red Handbook for Mental Nurses (1923)”, which became the basic training text for mental nurses (Rollin 1986, p.279). It could be said that this was the beginning of a claim for professional identity and the continuing search for the clarity with regard to the ‘role of the mental health nurse’.

The prevailing debate regarding the lack of clarity of the role of the mental health nurse certainly appears to be rooted in the history of the discipline. In his study exploring the reflections of a mental health nurse in the nineteen fifties, Nolan (1994, p.151) reminds us of the limited nature of historical research in the field of mental health, identifying that accounts of British psychiatry have been told “largely by amateurs”. He proposes that until recently these accounts were premised from two

discrete perspectives. The first of those from now retired medical practitioners who present a picture of a science based discipline developed to improve the position of a minority group i.e. the mentally ill. The other position came from 'administrative' historians who presented a picture of old style institutions, lauded doctors and extreme case patients. However, it could be said that the problems associated with accessing historical accounts are largely dependent on availability of records and archives many of which have been lost as asylums and institutional reform progressed. There followed a new vision regarding the care of the mentally ill that was reflected in a shift in the rhetoric used to describe this social group. The insane were now referred to as patients; asylums referred to as hospitals and attendants as doctors and nurses. Thus likening mental illness to physical illness. According to Barnard (1968, p.144) in his history of English Education, it was at this time that society began to recognise the value of education as espoused by theorists such as John Stuart Mill, Herbert Spencer and Thomas Huxley. These theorists were influential in promoting compulsory education, recognising individual differences, endorsing the notion of women's formal education and stressing the functional utility of education for society that culminated in the Education Act of 1870 (Barnard, 1968, p.115).

The development of nurse education was in keeping with the political and philosophical climate of the time, knowledge and skills training for nurses across disciplines was seen as the way forward. Thus, it was not only those nurses who were involved in caring for the physical health of individuals who engaged in nurse education. As greater knowledge and

understanding of mental illness evolved, the need for knowledgeable and skilled practitioners became a key element of caring for this particular client population.

Chambers and Subera (1997) highlight the fact that in recent mental health nursing textbooks the introductory chapters no longer contain much, if any history of nursing content. They make the claim that this absence represents a disregard for the past as it relates to the development of professional identity. It is hoped that the previous discussions have in some small way assisted in repairing this deficit. Much contemporary research related to nursing history *per se* is couched within feminist discourses with a strong emphasis on the subordination of the largely female workforce within a patriarchal working environment. Discourses relating to power relations support this view, Bourdieu (1984). However, contrary to the perceived female gender subject position in the nursing population as a whole, early mental health nursing was largely a male domain. Issues related to gender and nursing is taken up in the following section.

2.4 Nursing, Gender and Identity

Historically, nursing as a profession is perceived as being composed of a female dominated workforce. This is reinforced by rhetorical constructions of care and caring commonly used to identify what a nurse is or what nursing is about. The prevailing argument being the symbiotic relationship between nurses, nursing practice, the concept of care and the feminine gender (Walby, S. 1990., Bornat et.al. 1993., Walmsley et. al.

1993 Lerner, G. 1997). Stereotypical notions of nurturing and caring are viewed as the underpinning premise from which these assumptions arise. Cash (1997, p.141) claims that the “foundation of nursing and therefore the status of nursing knowledge occurred within a context of professionalisation where...the professions perform certain tasks formerly performed within the family”. A great deal of nursing research stems from a feminist research paradigm. Lupton’s (2000) study, drawing on in-depth interviews of men in non-traditional occupations such as nursing, claim that men face a range of challenges to their sense of masculinity. Lupton (2000) suggests that gender identity and occupational identity become misaligned during the transition period for men who enter nursing. However, he proposes that they attempt to realign these identities either through reconstructing or rationalisation of the nature of their occupations.

Burton (1998, p. 204) in his research on social roles highlights the importance of “self-in-role” as a means of situating personal identity in individual social roles. In his work Burton (1998) espouses the relationship between integrative meaning in role specific identity and psychological distress. Thus, it may be proposed that men, within a female gendered profession such as nursing, migrate towards occupational roles that reflect traditional patriarchal gender differences such as administration. It is further proposed that specialist positions such as community mental health nursing and forensic mental health nursing among others, may assist in alleviating a social role cognitive dissonance. This discussion is taken up by Evans (1997). In his paper, Evans (1997)

suggest that men are aided in this by the patriarchal culture of institutions that create and perpetuate male advantage, as well as by women, who according to Evans (1997, p.229) consciously or unconsciously nurture the careers of male colleagues in nursing. Milligan's (2001) study uses ontological hermeneutics to identify the concerns that male nurses expressed in fulfilling their perceptions of care in practice. However, in a study on job stress and satisfaction among nurses conducted by Kirkcaldy and Martin (2000), outcomes of the analysis of data from 276 questionnaires revealed that there was no difference in relation to gender in occupational stress. This appears surprising given the multiple roles women appear to have in to-day's society. The outcome of Kirkcaldy and Martin's (2000) research is endorsed by Evans and Steptoe (2002). They hypothesised that despite the possibility of gender differences in work stress among males and females working in accountancy and nursing, they found that this was not the case where both genders worked in the same occupation category.

Despite the notion that a male workforce in nursing is relatively new. Macintosh's (1997) historical research on the study of men in nursing retells the history of nursing with emphasis on the frequently neglected place of men in it. Macintosh's (1997) study reveals that men have had their place in nursing for as long as records have been kept, but that the influence of the female dominated 19th century nursing movement has largely influenced nursing's historical ideology. This reflects the position of men in mental health nursing who have historically been the predominant gender workforce. Boschma (1999) however, in his study of

gender specific roles of male nurses in Dutch asylums from 1980 – 1910, he claims that the introduction of somatic treatments and the development of nurse education created a gender shift in recruitment, with females being afforded new opportunities to work in this area of practice alongside males. Boschma (1999) also suggests that the criteria for selection of males and females into the professions were also gender orientated. In the early 1990's the labour market provided an ample supply of females looking for work opportunities. Boschma's (1999, p.16) study illustrates that "female competence was judged in terms of character, decency and a healthy outlook" whereas in recruiting males as nurses

"most directors underscored that they preferred to hire male nurse applicants who already had a skill or trade....The new notion of male nursing reflected an ill-defined compromise of skilled artisan work and patient care".

Nolan (1998) highlights the development of recruiting demobilised servicemen to take on the role of nurses in the post war period. With the increase in male recruits, came the Society of Mental Nurses and The Association of Chief Male Nurses (1953 –1973). Both of these organisations were founded with a dual purpose. First, there was a need for a forum in which the work of mental health nurses could be shared. Secondly, there was a need to provide a support network for male nurses who were excluded from the Royal College of Nursing. The membership of this institution at that time was for women only. This was a reflection on the gender position of nursing at that time. It is in the narratives recorded from these fora that many creative, nurse led initiatives designed to improve the lives of the mentally ill were identified. It also provides a

graphic picture of the ordinary lives of patients and nurses as constructed by mental health nurses of that era. Nolan (1998) further claims that mental health nurses who were demobilised after the war were inevitable 'movers and shakers', with the confidence to campaign to raise the status of their profession. This had a significant impact on nurse education and nursing practice and assisted in the development of mental health nurses' professional identity. Matters related to the professional context of nursing are discussed in the next section of this chapter.

2.5 Professional Context

Much of the concern with nurses' identity is embedded in the concept of nursing as a profession and nurses behaving professionally. The general premise being that identity is constituted in a range of political, ideological and social discourses. The discussions that follow include some salient issues in this debate.

Questions regarding what constitutes a profession have a long history. Attempts have been made to identify a clear set of distinct traits that characterise all professions. Cohen (1981, p.3) seeks to address the question of "why, after over a century of service and a decade of intense discussion of the problem of professionalism, has nursing not achieved its goal of being a fully fledged profession, with a well defined knowledge base and a territory to call its own?". Miller (1998) identified key characteristics following a survey of twenty one authors definitions of professions, and reduced these to the following elements:

1. skills based on theoretical knowledge
2. the provision of training and occupation
3. tests of competence of its members
4. organisational adherence to a professional code of conduct
5. the concept of altruistic service

Whilst statutorily granted self-regulation and autonomy, as a professional criteria, has been discussed by Friedson (1983). A small number of occupations such as medicine and law have, historically been privileged with the status of profession. However, emerging occupational groups, including nursing, conform in a more or less way to these criteria, they have not been considered to have the same standing as medicine or law, for example. The shift of nurse education into higher education may add strength to the case for nursing being viewed similarly. One of the key areas in nursing practice is the concept of 'professional' practice. There is a notion that one is acting 'professionally' when adhering to clearly stated rules and protocols. In nursing, dictates having been laid down either by the government, professional bodies or by those who employ nurses. Professional awarding bodies for nursing neatly package the concept of professionalism into clearly defined behavioural guidelines, presented as Codes of Professional Conduct (UKCC). These are designed to act as frameworks for practice within which nurses are required to comply in order to remain licensed to practice. Professional nursing entails various obligations to comply with these codified practice guidelines. Similarly,

the preparation of student nurses for their role is required to reflect these dictates in both curricula and in support for students in training.

It has been generally stated that the professional dominance of certain occupational groups is clearly grounded in the possession of a discrete body of knowledge, which forms the basis for applied specialist skills. This could be construed as a crucial feature of the exercise of professional power and a means of generating a 'social distance' between professionals and others. Hoyle (1974, p.17) describes the academic community's criteria for valid knowledge as "codified, systematized, universalistic knowledge generated by experimentation and independent sceptical scholarship and, where applied to practical and personal problems applied in a rational and detached manner". Traditional professions such as law and medicine appear to have well-established foundations of expert knowledge. In recent years, aspiring professions such as nursing, social work and teaching have similarly attempted to define the body of theoretical knowledge underpinning their own practice. Problems in researching professionalism have been identified by Helsby (1995) who examined the topic in relation to teacher's construction of professionalism in England in the 1990's. Helsby's (1995, p.329) claim being that whilst education was an important vehicle for teachers sense of professionalism, the teachers themselves played an important part in asserting or denying their own professionalism. One of the problematic aspects of nurse education and practice may be the element of uncertainty that still remains in the knowledge base underpinning the professional nurse's work, despite attempts to ground their knowledge base firmly in academic

disciplines and to develop research and scholarship (Benner and Wrubel, 1989, Perry and Jolley, 1991). Related to the occupational sociology perspective there has been much debate about the quasi-professional characteristics of nursing which often centre around issues such as occupational subordination or nursing being 'women's work' and the notion of ownership of a discrete body of knowledge for the profession (Benner, 1984). This notion is supported by Arnold (1996) who used Foucauldian theory about power, discourse and panopticon to outline a 'geneology' of nursing as being historically a female occupation subordinate to medicine. Schrock (1992) in her doctoral non-experimental study concluded that whilst men had higher earnings and hierarchical positions within nursing, the profession mirrors the societal power differential between men and women, with men having more power. Bourdieu's (1984) work on social classes as they relate to each other through power relations suggests that dominant hegemonic differences are recognised within society albeit not necessarily legitimately accepted. This could be placed within the context of male female differences as well as inter/intra professional differences with nurses and nursing falling into the subordinate category. However, in her doctoral thesis, Chiara (1993) carried out an ethnographic study of narrative analyses of 52 women of various ages, ethnic identities and career histories in nursing. Her findings suggested these women, as nurses, felt they could make a difference to people's lives. In some ways mental health nursing has challenged feminist nursing discourse. Nursing in psychiatry has been, historically at least, predominantly a male

dominated nursing profession as discussed previously. Interest in this field of research remains constant. Torn and McNichol (1998) use focus group discussions to explore the concept of the nurse practitioner role and the complexities of advancing clinical specialism. Swanwick and Barlow (1994) examine the 'caring' role of nursing and where this fits into the academic, arts and science debate of Higher Education. Burrow (1993) discusses the conflicting position forensic mental health practitioners find themselves in regarding their identity as specialists within mental health practice at the interface of nursing and criminology. Fagermoen (1995), in a two phase study doctoral thesis, incorporating content analysis and hermeneutics identified that human dignity and altruism were the predominant values underpinning nurses professional practice, these coupled with intellectual and personal stimulation and the interpersonal relationships with patients and relatives were the bedrock for professional identity. Others have taken up this concept of 'meaningfulness' in relation to the work that is performed by individuals. McConnell and Dadich (1999, p.13) address this further in their qualitative study by identifying "validation of professional identity" as being one of two major categories to emerge from the content analysis of their research data. Validation was demonstrated by client satisfaction with care provision and by personal satisfaction of the individual nurses experience of socialisation into the culture of the work environment and by their fulfilling appropriate work related roles. The synergistic relationship between professionalism in nursing and nurses' perceptions of excellence in nursing care was highlighted in an earlier qualitative study by Coulon

et al. (1996). The concept of professionalism as something which is symbiotically related to 'good' practice is also addressed by Nixon (1996) in a qualitative study drawing upon analysis of data generated from interviews with lecturers in higher education, the findings of which claim that institutional conditions are key for such practices to happen. Within the nursing profession, there is also a need for nurses to work autonomously with clients and to have their work recognised as a unique and valuable contribution to the health and well being of the client. There are those who believe that 'professionalism' is about exercising judgement and autonomy. In a qualitative study carried out by Morral (1997) the analysis of data generated from diary-interview schedules highlighted that mental health nurses working in the community experienced *de facto* clinical autonomy, characterised by unsupervised and arbitrary decision-making, suggesting the issues related to nursing autonomy need to be more robustly addressed.

The notion that professional identity is something that emerges as a result of and alongside professional history and inherited knowledge is highlighted by O'Neill (1999) in a paper concerned with the loss of professional identity of social workers concluded that the development of social work identity was embedded in bureaucratic discourses such as professional certification, accreditation, ethical codes of conduct. While Harrington (1995) in a descriptive study for his Doctorate in Education, claims that professional identity is an integral component of a process of professional change, which encapsulated becoming part of a profession through the processes of socialisation into the professional role, and, by

being a professionally recognised provider of care. One of the challenges in determining professional identity in mental health nursing is that nursing in itself is extremely complex. It is a highly varied profession coloured not only by different practitioners and practices but also by discrepancies between countries with regard to initial education programmes and post registration programmes. As services change and respond to the dynamics of socio-political and economic change, so the roles and functions of professionals within these services evolve and take on new meanings. Mental health nursing is not alone in this metamorphic situation. The ongoing trend in blurring of professional boundaries, integrated team working practices and professional collaboration in health care education and delivery presents challenges for the identification and clarity of professional identity as illustrated in Lloyd and Duveen's (1999) work. Their study explores the challenges and opportunities facing occupational therapists working in mental health services within a culture that is promoting generic skills for health care practitioners. Gray (1998) addresses difficulties experienced by many occupational therapists in their struggle to maintain the 'occupation aspect of their role' as both a practice and a means and an end, in their professional identity. She concludes by suggesting that

“the survival of the profession may rest in each occupational therapist's ability to give coherent and attractive answers to the prevailing questions “What is occupational therapy?” and What do occupational therapists do that is different from other health care professionals?”

(Gray 1998, p.363)

Osteopaths experience a similar problem as identified in the study undertaken by Cameron (1998). The processes involved in teaching and learning within nurse education is the focus of Caldwell's (1996) doctoral thesis. In this study, the claim is made that the inter-relatedness of curriculum design, teaching methods and the written work of the students contributes to shaping professional identity. This is endorsed by Day et al. (1995), who claim that students become socialised into nursing during their education programmes through interactions with lecturers, taught elements of their programmes and exposure to practice environments. The impact of the socialisation processes at work within the education environment that prepares nurses for their professional role is an interesting one and worthy of further empirical work. It is also interesting to note that professional identity is in itself evolutionary and dynamic. It exists within a time frame and within a particular professional context. In carrying out our everyday work activities we wear many hats and appear on the 'work's stage' in many guises. In occupying certain positions within society, we are located in a frame with other people. As illustrated in earlier discussions, certain expectations arise from these roles that we play. These expectations in nursing are determined within a framework of rights and duties. The complex ways in which roles are performed suggest that social interaction is far from unambiguous and the behaviour that expresses role is far from straightforward. Thus, whilst we operate within identifiable or definable social structures, it is proposed that there is scope for variation in role performance depending on the particular context within which individuals operate. This is the case for mental health

nursing. It is a highly complex discipline, which encompasses a diverse population with multiple needs and is practised in a wide range of challenging contexts. Anderson (1999) addresses some of the challenges met by mental health nurses in working with young people who deliberately self harm. In his work he stresses the importance of mental health nurses' understanding of individual experiences of family and social life and the sophisticated skills required to work at a therapeutic level in this context. Mental health nursing research over the years has attempted to address some of these issues as a means of better understanding the nature of the discipline. As has been seen from these discussions, education is perceived to be one of the central contributors to assisting and influencing the creation of social roles. Nurse education over time has moved significantly and with each era, new issues arise. The following discussions concentrate on mental health nursing identity through education and practice.

2.6 Education and Practice Context

Current nurse education, within higher education, has to cope with theoretical overload. Nurse education curricula selects from the range of theoretical disciplines, which contribute, to the body of knowledge known as nursing such as natural science, psychology, sociology, physiology and others. The content of nurse education and training programmes is designed to ensure that, on successful completion, the nurse has the necessary knowledge and skills to be safe and competent practitioners. The underpinning educational premise is to contribute to the manufacture

of social order. Nurses have a particular role to play and nurse education assists in the process of preparing them to be 'fit for purpose' (UKCC, 1999). Guidelines related to the content of nursing programmes at initial and post registration level are made explicit by the National Boards for Nursing, Midwifery and Health Visiting (NBS) and are now subject to Higher Education Funding Council (HEFC), Quality Assurance Agency (QAA) Subject Benchmarking Standards.

In the discussions that follow, the notion of the education context serves to highlight the key issues facing health care provision within the current social and political climate. As a result, these discussions impact on nurse identity. Contemporary practices are dictated by the present Government, and impact on the key players in health care education provision. The emphasis within the profession is centred on the quality of client care provision. As a result, higher education and nurse education and practice are required to exist in synergy one with the other. Change appears to be the rule rather than the exception within the worlds of higher education and the National Health Service (NHS) as we move forward into this next decade. This recurring scenario of re-invention takes place in response to demographic trends, the resultant changing needs of society and the political policies of the day. The outcome is that we have seen a raft of Government policy documents over the past few years which set out proposals to 'modernise' the NHS in the United Kingdom (appendix iii). The political rhetoric of these official papers offer discourses that impact on health care, practice and education in ways that suggest that what was in place before their construction was outmoded, did not meet the

contemporary health care needs of users of the services and fell short of meaningful educational requirements for an effective health care workforce. Bruce et al. (1999) highlight the impact that health service reform has had on mental health services and the pressures that this has placed on primary care teams. In creating a role for community mental health practitioners with general practice, Bruce (1999, p.1061) claims that there have been improvements in communication, interpersonal and inter-professional liaison and in client compliance with treatment regimes. However, there is the potential that the impact of constant change for practitioners is a general lack of clarity with regard to who they are and what it is they are doing as practitioners.

From a national perspective, the introduction of devolution and the subsequent creation of the Scottish Executive have changed the way in which Government takes place across the UK with each of the devolved administrations being afforded the opportunity to address their own national needs. As a nation, Scotland's health needs are fundamentally important. Scotland has its own problems in terms of heart disease, stroke, cancer, and teen-age pregnancies. And, with specific reference to this research, mental health issues, drug and alcohol abuse are particularly problematic in Scotland. Scottish Executive research funding initiatives are designed to address this agenda. In a UK wide review of health care professionals contribution to the continuing care of people with mental health problems, commissioned by the United Kingdom Central Council (UKCC), in light of major mental health policy developments, it was noted that few of the 221 papers, 47 projects and 142 reports addressed

nurse education and training issues. The report also claims that many individuals are dissatisfied with old ideas and approaches. These views being influenced, the report claims by higher education's influence on health care practitioners ways of thinking. This is particularly so for those who have undergone degree programmes in nursing and health care. Contemporary nurse education programmes are designed to prepare individuals for registration on the United Kingdom Central Council for Nursing (UKCC) professional register. Whilst many of the individuals who exit from these programmes seek employment in local areas, in today's world people frequently have to migrate around the UK and beyond to find employment opportunities and to progress their career development. It is important therefore that they are suitably prepared to transfer existing knowledge and skills in new environments and are supported in new learning and skills acquisition. It is equally important that their educational qualifications and professional licence to practice are equally transferable. The increasingly complex world of healthcare requires that health care professionals should function effectively in an inter-professional 'team' climate. To address this in a meaningful way, a more robust and collective approach to multi-professional curriculum design and development is proposed by the current Government. Research such as the Department of Health (DoH) commissioned project by Reeves and Pryce (1998) evaluated the effectiveness of inter-professional teaching and learning opportunities for nurse, dental and medical students as they experience sharing a 'module' on community care certainly assist this process. It could be argued that this research also

highlights how tentatively the professions are moving in this area. The researcher proposes that one shared module across a range of health care disciplines is indicative of the extent to which this approach is viewed cautiously by the respective professions. It would appear, therefore that there is a long way to go before fully integrated curricula for health care professionals is realised. The World Health Organisation (WHO) goal of 'Health for All' by the year 2000 was premised on health care educationalists actively seeking ways of bringing together health care education at undergraduate and post-graduate levels at an interdisciplinary level. The underpinning premises being that "inter-professional education...enables health personnel to respond to priority health care problems that are known to be amenable to teamwork" (Banks and Janke 1998, p.132) The ethos of the WHO position is embedded in the Government white paper 'Designed to Care' (1998). This has been marked as 'a turning point for the NHS in Scotland' by the current Prime Minister, Tony Blair. It formed the basis for developments that are currently shaping health service education and provision throughout the country as a means of moving it towards being the 'modern and dependable service that once was the envy of the world'. Higher education and the NHS exist in tandem in a climate of accelerated change. They both have their own unique concerns, such as recruitment and retention and social inclusion, and it is right that individually they recognise these. However, they both have efficiency, effectiveness and quality as overarching priorities. These are areas that impact on all those involved in health care delivery and health care education. As change

impacts on education and practice, multi-professional shared learning has been advocated as the way forward. The Minister for Health and Community Care in Scotland, of the day, Susan Deacon strongly emphasised the importance of partnership working. However this needs to be meaningful for the individual professions in ways that allows them to retain their professional identity whilst employing collaborative principles. Boyd (1999, p.377) alerts us to the problems of this idealistic concept by suggesting that educational institutional life is problematic in assisting individuals to “reconcile professional self identity with institutional reality”. In his paper, he cites organisational demands as being counter productive to the achievement of personal professional goals for lecturers as well as compromising critical scholarship and transformative pedagogy. Similar concerns are raised by Brooker et al. (2001) in their study mapping university accredited, post-registration, education programmes for mental health nursing. It would appear therefore that nurse education has some way to go in order to achieve the proposals of Government and the needs of the profession. In this research issues regarding education and training are raised by the nurse participants and are presented later in this work. It can be seen that complex concepts such as nursing identities are not easy to compartmentalise and neatly define. A range of external and internal factors influences and shapes them as the following discussions illustrate.

2.7 Definitions, Perspectives and Representations

Reflections on nursing history, the nature of its workforce and its evolution as a profession can be powerful tools in the development of professional identity for mental health nurses. However, despite claimed advances in knowledge and understanding about mental illness, there remains public wariness of those with mental health problems and lack of real understanding about the role played by practitioners in working with this client group. This wariness exists within the wider world of the nursing profession as well as in the public domain. This is often compounded by the behavioural manifestations of mental disorder as expressed by some who experience problems in this area. Mental health nurses frequently work in ways that are not immediately recognised. The skills they employ falling into an 'unseen' domain such as interpersonal, communication and counselling skills. Thus mental health nurse identity is made problematic. However, people come to a 'vision' of mental health nurse identity that reflects what they know or understand about the discipline. That 'knowing' has many origins including socio-cultural, personal experience, academic and scientific knowledge as well as media and film representations. Media representations contribute to the construction of those with mental disorder as being dangerous or strange in the ways in which their coverage deals with incidents involving mentally disordered individuals. There is a dearth of literature that constructs mental illness as dangerous, with mentally ill individuals frequently portrayed as acting violent. This is evident in media studies

carried out by authors such as Fruth and Padderud (1985, p.384) who claim that

“a review of the literature on public attitudes toward the mentally ill reveals the fear, dislike and distrust engendered by public perceptions of the mentally ill as dangerous, unpredictable individuals who cannot, or will not, be held accountable for their behaviour”.

Wilson et al.'s (1999) discourse analytic study of a sample of fourteen television drama episodes with a mental illness storyline identified that storylines were based on polarities of normal-strange; normal-abnormal; normal-dangerous, with the mentally ill character presented as looking unusual, behaving strangely and attacking without provocation. The viewing public were given only a generic label of 'chronic mental illness' for the character's problem. There is a similar negative construction of mental health practitioners when incidents of bad practice in some institutions are brought to the public's attention. This is illustrated in the interest in violent episodes in the community (Bowers, 1997). This is taken up by Turnbull and Beese (2000) in their study of community mental health nurses working within the criminal justice system. They highlight that there has been a paucity of preparation for this specialist role and this leads to confusion regarding professional identity. The custodial role that is part of the historical legacy of mental health nursing brings into the frame the involvement of mental health nurses in the care and treatment of clients who demonstrate acts likely to harm themselves and others and whose behaviour sits on the boundaries of or spills over into the realms of criminal behaviour (Polczyk-Przbyla and Gourney, 1999).

Any study exploring mental health nurses' identities should recognise the complexity of the nature of phenomena of mental disorder and the practice of mental health nursing. As Peplau (1994, p.7) reminds us, "the definition of the contents and scope of psychiatric mental health nursing is still incomplete." It would be easy to attempt to neatly package the concept into one single unified definition, but it should be cautioned that any attempt to compartmentalise areas of human existence into simple operational definitions belies the complex nature of the species. The social activity we call nursing is constantly changing. Also since it contains a diverse range of activities within it that borders with other activities, such as social work, occupational therapy and clinical psychology, the task becomes even more complex. Although definitions of mental health and mental disorder abound, they may be considered guilty of being reductionist. Szasz (1974) suggests that attempting to define is to adopt a constraining perspective and alerts us to ask what it is that we are hoping to achieve by defining.

Throughout history, individuals have attempted to deal with behaviour that was perceived to be socially unacceptable, with constructions of mental illness intrinsic to constructions of the nature of human beings and perceived civilised society. It may be suggested that most of us have a conceptual notion of what constitutes severe mental disorder, for example violence, aggression and extremes of behaviour, just as we have a notion that contentment and happiness are commensurate with being mentally healthy. In discussing feelings, we use descriptive terms, which in today's society have medical connotations, such as 'a bit low', 'a little

depressed' or 'feeling high'. To accept terminology which contributes to the medicalisation of every day experiences is to acknowledge Foucault's (1998) concern with the ways in which various regimes of knowledge, which include schools, academic disciplines, psychiatric and medical professions and religion, function so as to generate discourses and practices which invite us into their 'realities' and in accepting these invitations we are guilty of subjugating ourselves. However, between the discourses of 'madness' and 'normality' lies a vast expanse of indeterminate vagueness. Sitting at points along the continuum are people in crises of varying levels and guises and who transcend a wide age span from young children, adolescents, young and older adults and the elderly. There are people with mental health problems within our institutions and there are those struggling to cope with their problems in the wider community. There are those with recurring mental health problems, who are known to the health care services and there are those who attempt to get by on their own using whatever resources they have to hand. There are those for whom their mental health problems are either precursors to or the result of other social problems such as unemployment, homelessness, relationship difficulties, crime and deviance. Mental disorder has no discrimination.

It is also practised in extremely diverse situations, apart from traditional institutions. Mental health nurses are to be found in prisons, drug and alcohol clinics, general practice surgeries and indeed accident and emergency departments. It is an area of nursing practice that cannot be easily defined by any reference to a single unified list of tasks, skills,

nursing behaviours. Neither are its goals or objectives fixed for all time, except perhaps at a rather general level. It is proposed that if we are to better understand those who are involved in caring for this particular population we need to listen to what it is nurses in practice say they are doing in their work with clients in their respective practice areas. Early research in mental health nursing attempted mainly to define and evaluate what was considered to be the role of the nurse (Peplau, 1952). The introduction of new technology has opened up creative possibilities for research in nursing. Bowers (1997) capitalises on this in his work exploring the professional identity of psychiatric nurses through an examination of their discussions with each other on a nursing Internet site. However, this study again presents lists of psychiatric nursing topics and issues that nurses talk with each other about, along with the frequency and duration of these interactions. The international professional identity that is suggested in Bower's (1997) study centres on topics such as nursing models, social labelling and community care policies that are matters of debate within the profession anywhere in the world. Whilst this work is interesting from a content analysis viewpoint, its focus differs significantly from this research study.

The need for continued research in mental health nursing and the development of greater insight into mental health nursing practice is central to ensuring this discipline's rightful place alongside other professions. Smith (1978) alludes to the fact that if nurses are not more judicious with regard to their involvement in nursing research, they may find themselves on the outside looking in. This cautionary note from

Smith (1978) serves to alert nurses to engage more productively in nursing research. Health warnings of this nature are particularly important for mental health nurses, whose practice boundaries blur significantly with those of other professions allied to medicine such as social work, occupational therapy and clinical psychology. As many of the specialist areas of mental health nursing sit at the interface of other social domains, the question of individual professional identities become more confusing. Research that is specifically concerned with the occupational identities of nurses appears to be thin on the ground however. Scoggin (1996) explored the ways members of the nurse-midwife fraternity defined their collective occupational identity in a nation wide survey of 300 nurse-midwives in which they indicate that nurse-midwives identify occupationally with midwifery rather than nursing or medicine, despite the alliance with these other professions. Degelin et al. (2000) examines differences and similarities in the identity of Australian and English nurses, looking at how each country has developed its individual ideological and strategic frameworks. More relevant to mental health research is the work of Moir and Abrahams (1996) who, in their discourse analytic study, explored student nurses' reasons why they as individuals made particular career choices. In their study, Moir and Abrahams (1996) highlight the negative contrast structures that are made between general nurses and mental health nurses as contributory factors in the development of a positive and distinctive occupational identity. Discourse analytic studies albeit less frequently used in the past in nursing research, are beginning to contribute

significantly to the repertoire of research methods in health care education. Potter and Collie (1989) use this approach to explore different linguistic constructions of mental health policy by lay people. Cowan (1996) has similarly used a discourse analytic approach successfully in her doctoral study of the general public's attitudes to people with mental health problems. More recently, Mohr (1999) has attempted to deconstruct the language of psychiatric nurses' documentation and record keeping through a 'Foucauldian' lens which highlights issues of nurse/patient power relationships constructed by practitioners in their production of professional documentation and reports. Albeit interesting research topics, little direct work relating to the professional identities of 'mental health nurses' could be found. However, a recent guest editorial paper by Glenister and Tilley (1996) outlines 6 discourses that they suggest have a bearing on mental health practise. These being the medical discourse, social disablement discourse, discourse relating to communality between mass and the excluded minority, human rights discourse, social integration discourse and consumerism discourse. The researcher would suggest that elements of all of these are inherent in the nurse participants' constructions of their professional identities in this study.

It is proposed, from this discussion on definitions and representations that there is no 'encompassing discourse' that is carefully constructed and thought through, epistemologically sound, and with a consistent 'take' on mental health nursing. One of the unique elements of nursing is its somewhat 'schizophrenic' nature and the 'multiple voices' that contribute

to its construction. As well as it's lack of adherence to one epistemological stance. It is not tuned into one particular perspective of thought or practice. However, on a positive note it can be said that this is one reason why it is amenable to the degree of change that has and is central to its development.

2.8 Conclusion

The complexity of this research topic is evident from the preceding discussions. This chapter has embraced a range of inter-related topic areas that have served to provide a contextual orientation of commonly accepted discourses. Individually and collectively they assist in orientating the reader to this research project. Each area discussed presents its own contribution to the construction of identities in nursing. From the previous discussions, there is a strong persuasion that identity, as it applies to mental health nurses, has a social orientation that transcends time, place and person. In chapter 3, there follows discussions related to the social constructionist approach as adopted in this research. Providing insights into the use of language as a tool to be employed in the construction of mental health nurse identities.

Chapter 3: Social Constructionism, Identity and Reflexivity

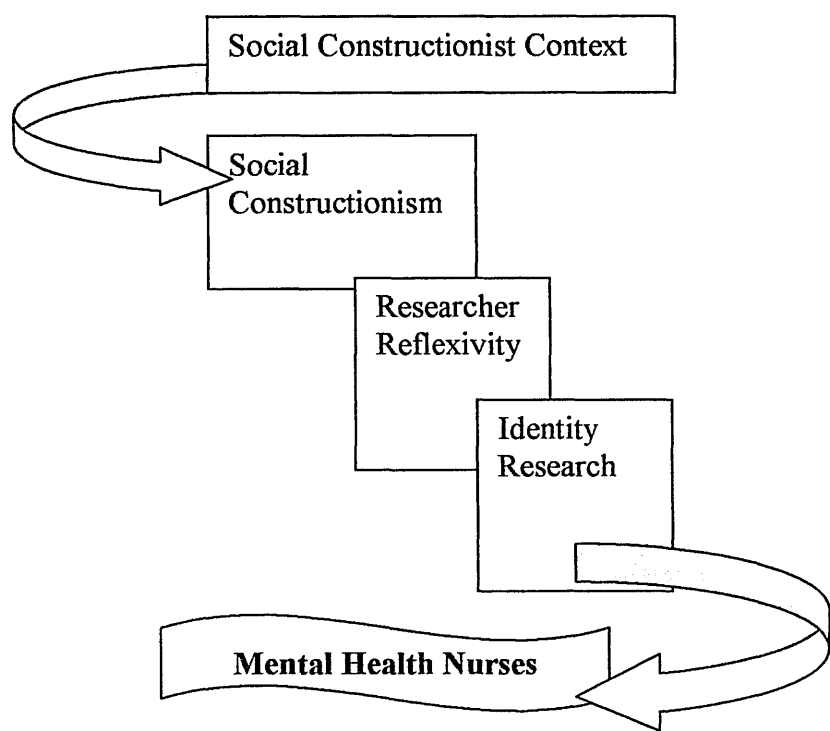
- 3.1 Introduction
- 3.2 The problem with the traditional view
- 3.3 Social Constructionism: a discussion
- 3.4 Researcher Reflexivity
- 3.5 Researching Identity
- 3.6 Conclusion

3.1 Introduction

The preceding chapter presented a review of literature that represents commonly held views of mental health nursing. These views may be interpreted, as Gergen (1999, p.9) suggests as one side of the 'out there versus in here' world. In this chapter, a case will be made for a discourse analytic, social constructionist approach to the study of mental health nurse identity. Thus, the discussions in this chapter move from the traditional and commonly understood contextual understandings of mental health nurse identities and practices, to presenting social constructionism as an alternative 'way of knowing'. In so doing, the case made in this research is strengthened for the use of a discourse analytic, social constructionist methodological approach. The premise is its discursive synergy with mental health practice. The researcher proposes that individual interpretations of the world and our experiences of it are central to working with clients with mental health problems. Listening to the accounts of those with mental health problems and accepting that they are 'the case' is an important aspect of mental health practice. Best practice in this field is that which embraces the concept of 'client centeredness'. Thus, the researcher suggests that utilising a similar approach to the study of mental health nurse identities creates a symbiotic relationship between this research and mental health nursing practice. Another aspect of mental health nurses work is personal reflection and self-awareness. In adopting a similar approach in this research, the researcher proposes that the synergistic relationship between this study and the topic under

investigation is enhanced further. Research reflexivity allows for ‘researcher’ issues to be made explicit and for the researcher to be ‘up front’ about areas of challenge, concern or potential conflict. Finally this chapter will look more closely at identity research studies as a means of situating this research within this growing field of investigation. Figure 3 below, conceptually represents the researchers construction of this stage in the research process.

Figure 3 Identity as Socially Constructed



3.2 **The problem with the traditional view**

It is proposed that the discourses in the preceding chapter represent a particular view of nursing and nurse identity that is universally understood as being 'the case'. Historical accounts of nurses’ practices and how they are positioned within the social, political and cultural experiences of a

particular time frame. These present a particular perspective of nursing identity which serves to illustrate a construction of nurses and nursing practice with whatever era in history one is concerned. Gergen (1999, p.13) affirms this view when he suggests that

"both cultural and historical study indicates, all such assumptions about "what we are really like" are precariously placed - products of a certain culture at a certain point in its history".

As to-day's present becomes tomorrow's history, the construction of mental health nursing will respond in a dynamic way in reflecting the current practices and policies of the day. Similarly, by constructing a social role category such as nursing as a 'profession' and producing clearly defined parameters for nurses as a social group, certain behaviours and performances associated with that role provide a construct of the nurse being a particular 'type' of professional, that is commonly understood in behavioural terms. By this it is suggested that nurses should be caring individuals, that they should hold a particular moral stance, and that they are a social group along side other groups within health care and have a particular social 'place' within that domain. Thus, as discussed in the previous chapter, it is commonly understood practice to identify certain characteristics and behavioural traits that serve to portray the defining features of nursing as a particular social group. Placing nursing, as a social category, within a complex social structure where each has its place and knows the boundaries of their individual positions alongside each other reflects what Sherrard (1995, p.139) refers to as Bourdieu's (1984) construction of social identity theory. A health care 'social group' such as

nursing could be seen to relate to other health care professional 'social groups' such as medicine in terms of power and status. Political and educational discourses provide an arena within which nurses exist as a product of contemporary and dynamic shifts in the political and educational positions of the day. Governments change and educational theory and policy shift accordingly. Therefore, the nature of nursing and 'the nurse' is similarly redefined. However, this is frequently done in ways in which common understanding of the position of nurses within society is recognised as being different in status to that of their medical counterparts. However, the road to 'becoming' a nurse is similar to that of other professionals in healthcare. That is, to 'become' a registered nurse, a particular type of education and training is necessary. Specified criteria have to be met and the end result is that individuals are given a 'licence' to practise. If we accept that these traditional and commonly understood constructions are the only ways in which nurse identities can be determined, there is little to distinguish nurses from pawns on a chess board, that can be moved from position to position but cannot be other than pawns with their movements controlled by others. The identities of nurses in these situations are determined by the rhetorical representations found in texts, archives, policy documents and codes of practice. In simple terms, from a traditional perspective. Identity, from this perspective, has been used as a "strategic tool" in producing taxonomies of society such as social structures and institutions as a means of "dividing up the social world and for saying something about those divisions" (Widdicombe 1998, p.192).

This research, however, proposes that nurses' identities are constructed in relation to the areas discussed in the previous chapter, as well as in relationship with the social practices nurses engage in and how they experience their world. With this in mind, the following discussions in this chapter serve to make a case for the research approach that has been adopted for this study. With the shift in political and professional idealism towards a health care system that is truly multi-disciplinary and an educational system that is multi-professional, the concept of social roles, power, dominance and subservience should, one would assume, become part of nursing history. However, it is also problematic from an 'identity' point of view, as will be discussed later in this chapter.

3.3 Social Constructionism: a discussion

As research in mental health nursing evolves, a natural phenomenon of that growth is that other ways of knowing and gaining insights become available to us. Thus adopting a social constructionist approach to this research allows us to explore the uniqueness of mental health nursing from an alternative perspective. Many traditional research methods follow a positivist paradigm. Speed (1991, p.396) suggests these traditional approaches espouse a strong definition of realism, which is "...the position that really exists, and can be discovered by people in an objective way and thus strongly determines what we know". Therefore positivism would appear to subscribe to the notion that 'the world is out there' and can be objectively observed and quantified through the use of measures and instruments. A strong criticism for this position is the

tendency for these approaches to depersonalise the individual and make particular claims about human nature. Stevenson (1996a, p.219) reminds us that positivist knowledge, whilst highly regarded, “is only one kind of knowing”. He concludes his paper by stating that merging research and practice, in this case mental health nurse identity and social constructionism,

“may encourage ‘knowing-from’, which is more relevant to people in practice because it is an ‘everyday kind of knowing’ that enriches the personal and professional experience of psychiatric nurses”

(Stevenson, 1996a, p.223)

It is true to say however, that there now exists a proliferation of research approaches adopted in the research world. Powell’s (1982, p.113) paper on recent trends in research illustrates this point. In his conclusion he states that “the subjects of the social and behavioural sciences are more complex than the research tools currently available to investigate them”. The researcher proposes that mental health nursing sits within this complex frame and that extending the methodological repertoire will assist in investigating many of the issues within this discipline. The notion that shared methodological methods can contribute to greater understanding should also not be lost. Again, this way of knowing recognises that rigid compartmentalisation may not always achieve the best research outcomes. Edwards (1997, p.114) discusses the concept of ‘shared knowledge’, arguing from the premise that knowledge that is ‘given’ is a rhetorical category that can be used by individuals in conversation for a particular purpose. Burr (1995, p.31) also suggests

“you don’t have to abandon traditional personality theory (as we

have seen, behaviourists and social learning theorists did a long time ago). But it is a useful starting point from which to explore the social constructionist views which have gained a foothold in social psychology in the last fifteen years”.

However, it is proposed that for this research, there are positive gains to be had in employing a social constructionist approach. Gergen (1999, p.33) suggests that it allows us to rethink "ideas of truth, self, objectivity, science and morality" and allows us to review the world of the mental health nurse with a wider lens. The affinity of adopting this approach in the study of mental health nurses' identity lies in the synergy between the primary emphasis of social constructionism on language use and the way discourse functions in social relationships. This sits comfortably with the ways in which mental health nurses engage in interaction and relationship in their work with people. Following a review of the history of psychiatric nursing, Barker (1990, p.346) suggests that

“a significant thread woven through most of the role model descriptions, identified interpersonal processes as the single, most significant, influence on the outcomes of care.”

The only methodology that social constructionism can claim is that there is no requirement to have a single definable methodology. In this sense the synergy between social constructionism and mental health nursing is again endorsed. It allows for more levels of understanding of complex phenomena than the straight positivist ‘measured mile’. Atkinson et al. (1991, p.159) summarise the position by claiming that it is possible, even likely, that the “insights of a bright imaginative researcher who followed no discernable systematic procedures for observation and note taking

could be of a consistently higher quality than the insights of a task orientated researcher who carefully follows the systematic methods of data gathering and recording prescribed by recent qualitative research textbooks”.

Social constructionism rejects the notion that ‘reality’ is limited to our senses. That is, the ways in which we see, hear or read about or experience the world as being unquestionably ‘the case’. It validates the legitimacy of non-sensory, intuitive knowledge, with the concept of ‘senses’ being a rhetorical construction that is rooted in the notion of how we experience our world. Thus mental health nurses identities are revitalised, and personalised in this research in the language that nurses use when explicating the processes by which they describe, explain or account for who and what they are in the world of nursing that they exist in. Gergen (1985, p.267) suggests, “constructionism asks one to suspend belief that commonly accepted categories or understandings receive their warrant through observation.” As such, we are asked to challenge the commonly ‘taken-for-granted’ knowledge of nurses identities as presented in the previous chapter and to accept that from the constructionist position the process of understanding is not automatically driven by the forces of nature. Rather, it is the result of active, co-operative enterprise of persons in relationship. As Gergen (1985, p.271) proposes, “the explanatory locus of human action shifts from the interior region of the mind to the processes and structure of human interaction”. In so doing the ‘why are things the case’ questions are removed from the domains of psychological processes to one which considers people in relationships. Whilst having

no one characteristic that can be clearly definable, social constructionism is premised upon four working assumptions identified by Burr (1995).

The first of these is the notion that social constructionism takes “a critical stance towards taken-for-granted knowledge” (Burr, 1995, p.3). From this premise, she states that “it is in opposition to what are referred to as positivism and empiricism in traditional science – the assumptions that the nature of the world can be revealed by observation, and that what *exists* is what we perceive to exist” Burr (1995, p.3). This has a particular resonance for mental health nurse identities. As a professional group mental health nurses are constantly subject to views and positions of others. These views and positions are often taken as ‘being the case’. This has been illustrated in the review of the literature presented in the previous chapter. The second position taken by Burr (1995, p.3) concentrates on the “historical and cultural specificity” in the way that we commonly understand the world. She suggests that “the particular forms of knowledge that abound in any culture are artefacts of it, and we should not assume that *our* ways of understanding are necessarily any better (in terms of being any nearer the truth) than other ways” Burr (1995, p.4). There are similarities again in this position with regard to mental health nursing. History and cultural specificity have an immediate impact on mental health identities in a world of frequent and dynamic reform. The third position taken by Burr (1995, p.4) is that “knowledge is sustained by social processes”. She claims that our daily interactions with each other are the practices during which shared ways of knowing are achieved. Similarly, it is proposed that the concept of what constitutes mental health

nursing knowledge and how we 'know' mental health nurses is also intertwined in the identity issues within this research. Practical ways of knowing more about the identities of mental health nurses is to listen to their accounts of the social processes that they engage in as part of their every-day activities. This is reflected in Stevenson's (1996a, p.219) notion of the importance of "words as tools that are used within language in order to construct narrative as a means of making sense of their world". The fourth position taken by Burr (1995, p.5) is that "knowledge and social action go together". She suggests that these 'negotiated' understandings could take a wide variety of different forms, and we can therefore talk of numerous possible 'social constructions' of the world. However, Burr (1995, p.5) also points out that "each different social construction also brings with it, or invites, a different kind of action from human beings." As will be evident in the analysis chapter of this work, the rhetorical constructions of identities evidenced in the nurses' talk are in themselves the result of social interaction and their talk about their social interactions.

Therefore, the researcher proposes that for the constructionist, the relationship between language and things in the world is not fixed in extent or character. That is, there is no necessary connection between objects, actions and states and what they are called. As such, rather than reflecting the world 'out there' language generates it. Pearce (1992, p.149), in his discussion on the social constructionist approach that focuses on the "products of the process by which construction occurs"

claims that those who focus on language use in the social processes of interaction, as is the case in this research, identify some key consequences associated with this approach. These being, that a “product orientated constructionist” can explain their work as “an alternative way of looking at familiar topics: identity, emotions, cognitions, social structures and the like” (Pearce, 1992, p.150). In the case of this research, the topic is mental health nurses’ identities. Secondly, “these constructionists claim to be able to meet the standardised canons of rigour, reliability and validity” (Pearce, 1992, p.150). In this research, later discussions address these areas. Thirdly, he highlights an “asymmetry between the activity of social construction and the product of that process” (Pearce, 1992, p.151). In this research it is the mental health nurse participants’ constructions of their identity that is the focus of inquiry. In particular, how these identities are rhetorically yielded in the ‘functionality’ of their talk. In his discussions, Pearce (1992, pp. 151 -153) makes reference to the seminal work of Wittgenstein (1953) and from that philosophical premise he suggests that social constructionists be encouraged to view words as “instruments characterised by their use” and to have a “use only in context”. According to Hartman (1991, p.275), “words not only reflect but shape our world.... Our shared ideas about reality are social constructions or products of social discourses that emerge out of and also shape social processes”. Burr’s (1998, p.13) attraction to social constructionism lies in its ‘liberatory promise of its anti-essentialism’, in the ‘different meanings with which our worlds become invested’. The liberatory gains to be had in adopting a similar position in this research

allows for the re-thinking of stereotypical, 'taken for granted' constructions of nursing and nurses. However, we are also alerted to the fact that in showing that things could be different, discourse analysts often "stop at this point, afraid of reifying alternative constructions, and remain 'observers and commentators' leaving the action for others to take" (Burr, 1999, p.15).

The researcher proposes that the previous discussions in relation to the congruence of mental health nursing and social constructionism provide a persuasive argument for the use of this approach in this research. In adopting this approach, it places mental health nursing in a leading position in the translation of constructionist thought through research and practice. As discussions move forward in this research, it is proposed that mental health nursing cannot be easily described or explained, it just 'is'. Stevenson (1996a, p.220) suggests that the 'way' of mental health nursing is not open to definition because it is a reflection of action and is itself sensitive to circumstances. He further proposes that the 'way' of mental health nursing may lie in its 'invisible skills', which are recognised by mental health nurses, but largely undetectable by those who are not familiar with the discipline. Michael (1994, p.57) reminds us that, "the problem that frequently faces psychiatric and mental health nurses is the inability to define their true role and value". He concludes by suggesting that mental health nurses should recognise and value their core skills and to successfully articulate this to others less knowledgeable about the topic. However, the researcher cautions that in highlighting the 'low visibility'

nature of mental health nursing skills is not to lessen the ‘high importance’ of communications and interpersonal relationships. These are a key feature of this repertoire of mental health nursing skills and as such part of the identities of mental health nurses. Language is part of our every-day life and as such it is commonly taken for granted. It is frequently given little real credit for the part it has to play in the range and scope of actions that are achieved through language. The discussions presented in this chapter thus far have been developed to present a persuasive argument for the use of a social constructionist methodological approach in this research. These discussions have demonstrated the natural synergy between the topic of investigation and the methodological position. In addition to this, the previous discussions illustrate that this approach is an alternative way of ‘knowing’ mental health nursing. The following section of this chapter will centre on the role of the researcher in this research. In particular, the reflexive nature of researcher involvement in the research process and outcomes.

3.4 Researcher Reflexivity

It is proposed that the reflexive processes at work in the nurses’ discourse in this research contribute to the production of their own constructions of their professional identities as mental health nurses. This is achieved by making use of commonly available discursive devices employed in their talk in relation to this topic. However, there is another notion of reflexivity. That is, its use as a strategy. That is to say that the researcher’s constructions of the participants’ constructions are in

themselves discourses in which claims are made. Finlay (1998) suggests that reflexivity offers a way to turn the problems of subjectivity in research into an opportunity. She provides examples from her own research illustrating how the reflexive process can unfold new understandings. She concludes by suggesting that reflexivity should be a necessary component of both qualitative and quantitative research. In promoting the central themes of philosophy, rigour and representation in research, Koch (1998, p.174) espouses that incorporating a reflexive account or “positioning oneself”, in the research allows the reader to decide whether the text created by the researcher is believable or plausible. This is Koch’s (1998) term for rigour. Whilst Hayes (1997, p.269) suggests that the reflexive character of research is where “the researcher and the researched are characterised as interdependent in the social process of research” and that this should be highlighted and revealed in the study. Hayes (1997, p.270) also argues that reflexivity in the “sense of bringing to the public light researcher subjectivities, tells a more complete account of the research process”. In so doing, it is proposed that it moves beyond “sanitised versions of scientific report writing” (Hayes, p.270). Weik (1999, p.802), in exploring theories of organisations, espouses Woolgar’s (1988, p.16) classification of varieties of reflexivity that range along a continuum from “benign introspection to constitutive reflexivity” as a means of illustrating the importance of the researcher situating themselves within the research process and considering carefully the premises upon which their research is developed. May (1999) draws our attention to the fact that reflexivity is

often the means through which the assumptions and values of social scientists may be uncovered. He proceeds to explore the reasons for the current pre-occupation with reflexivity as well as the consequences related to these practices. May (1999) concludes positively regarding the value of reflexive engagement in the research process. However, Holland (1999) alerts us to the fact that the term reflexivity is frequently used in so many senses that it tends to sustain confusion rather than clarifying any underlying issues. In expressing his commitment to reflexivity, he proceeds to illustrate the various uses of reflexivity that exist and makes 'concept' comparisons with the many definitions that 'paradigm' exercised in human sciences. Researchers who have adopted a reflexive approach in their work find this to be an empowering experience. Maxey (1999, p.206) uses a feminist reflexive perspective as a tool for questioning the boundaries of both the research topic and his engagement in the research process. He claims that the tensions related to power imbalanced in research "often stem from the problematic nature of the very boundaries we construct around ourselves and our work, in this case the researcher and the researched". The notion that researchers form part of the social world that they study is central to the concept of reflexivity. It is an iterative process that requires systematic personal feedback on the effectiveness of that process. Lamb and Huttlinger (1989) suggest that reflexivity is a process in which the researcher attempts to understand how personally constructed categories such as feelings and experiences may shape a study and then proceeds to integrate this understanding into the study. Allan (1997), in feminist ethnographic study of an assisted

conception unit, uses reflexivity as the use of self, as an instrument of the data collection processes and she considers that using herself reflexively in this manner led to changes in her assumptions about the methodology underpinning feminist research approaches. More particularly Allan (1977, p.465) concludes that the inclusion of men in 'women centred' feminist research, where men play important roles in the experiences of women, offers the potential for a new type of research. Similarly, Martin-McDonald (1999) acknowledges the use of reflection as a personal self-learning process in her ethnographic research study.

The reflective approach adopted in this research follows that of Frank (1997). In this position, the researcher is part of the social world that they study. In this case mental health nursing. Adopting this process involves thinking about the study you are about to begin, before you begin and continue that ongoing dialogue throughout the process. The reflexive process in this research is incorporated into the study by addressing the points suggested by Ahern (1999) as illustrated below. In order for the following discussions to read fluidly and to take on board the reflexive position, use of the first person singular will be made in the following 5 areas of discussion.

1. Researcher interest in undertaking the study

As stated in the introduction, my interest in this research stems from a range of key premises. I have a previous clinical background as a mental health nurse and I am familiar with mental health discourses in their widest interpretations, such as prevailing theories, attitudes and others. My present post is in nurse education and I am familiar with and in many

ways party to the development of the political and professional discourses that currently abound in relation to nurse education and practice. I also have easy access to mental health nurses as subjects for research purposes. I should also at this point confess that this work is in part, a means to an end, given my current position as Doctoral student. Thus as a Doctoral thesis, in some ways the structure of this work is more formal than it might necessarily be in other circumstances.

2. Clarify areas of subjectivity

I am aware that my background lends itself to potential interpretive subjectivity in terms of the 'insider knowledge' of what constitutes a mental health nurse. However I am aware of and acknowledge that this is premised from personal experience as identified above. However, this is a somewhat precipitous view as it has been many years since I was actively involved in practise activities. I am also aware that my position is simply that, mine and no one else's. I am and have been involved in mental health curriculum development for many years and as such have a particular position, as an 'expert', with regard to the role, value, function and nature of nurse education. This personal view is an area that I have had to revisit constantly throughout this work.

3. Possible Areas of Potential Conflict

This section involves exploring situations where publication or dissemination of the outcomes of this research might be problematic. In this domain, the methodology used may be the biggest hurdle. Qualitative methods are not new to nursing research, and discourse analysis in particular is a growing methodology. However, it remains challenging

and I am aware of the need to be rhetorically effective with regard to the rigour used in addressing this research. The potential area of conflict in this work lies squarely in the presentation of this research as a meaningful contribution to mental health nursing research. Studies at PhD level are required to contribute significantly to the development of knowledge or theory construction. It is my belief that this work will in its own right present a new way of looking at an issue that is both complex and contemporary given the current political discourses on health care and health care education. I am also confident that within the area of qualitative research this is a valuable and purposeful study. I can say this having been invited to present peer reviewed research papers related to this work at a number of national and international research conferences.

4. Gatekeepers Interests

This research comes at a time when the nursing profession is once again reviewing the 'fitness for purpose' of its practitioners. It comes at a time when political discourses are premised on professional integration at both educational preparation and practice levels. Nursing is developing new and challenging roles in light of these socio-political developments. Thus I believe this research will contribute to the developing knowledge of, and insights into mental health nursing practise and in so doing inform the educational preparation of its nurses and other interested parties.

5. Recognition of feelings that could indicate lack of neutrality

As an experienced practitioner and nurse educator, I have my own constructions and views of practise, as I experienced it. There are many examples within the data that have a 'certain' familiarity to 'my own'

experience of practise. However, they are not ‘my own’ experiences. Throughout the process of data analysis I was aware of the potential and indeed frequent desire to interpret the data from my own particular perspective. This has been a constant challenge throughout this work. It has required the development of a different way of reading and re-reading text and exploring the best ways of presenting data. All of which were new and challenging to me.

6. The new and surprising

This steep learning curve has also involved ‘getting to know’ theories and theorists whose work I previously had limited knowledge of. The opportunity for personal development, challenging the status quo in terms of research approaches and exploring different realities has been a positive experience. The data collection and analysis in this research has been interesting in terms of allowing me the opportunity to engage in discussions about my profession with practitioners and to listen to their constructions of their worlds. Their discussions include illustrations of what has not changed over time alongside new issues. The application of a social constructionist, discourse analytic approach has provided insights that have surprised me and contributed to my own repertoire of knowledge and skills.

7. Reframing the research process

This section is concerned with transforming research blocks into research opportunities. The challenge in this work has been the shift from the ‘so what’ to the ‘so that’s why’. Listening to nurses’ discursive constructions of their practice has proved to be an illuminating focus on not only what

they do but also how they convey what they do in their talk about what they do in practice.

For me, the inclusion of reflexivity in research requires time and practice. It needs to be fostered in a climate of support where views and positions can be shared. Largely this support should be generated through research supervision as well as support in terms of time and resources. This has been the case in this research. Opportunities have been available to talk through issues with my supervisors. These have helped me to 'see the light', or at least 'a light'. I have also been fortunate in the construction of this work to participate in methodological discussions with academics that are experienced and committed to discourse analysis. These discussions have been invaluable.

Ahern (1999) also suggests that the reflexive process continues at the post analysis stage of the research. This would include reflecting on the writing up process and potential for researcher bias in the analytic process. This was done as a matter of routine in this study and involved constant reading and re-reading of the data, listening and re-listening to tape recorded transcripts, ordering and reordering of the presentation of the analysis chapter and careful thought as to details and closure. Being a reflective researcher has been emotionally and intellectually challenging. However this is a worthwhile part of the research process and one that has been of value both professionally and personally.

Taking the reflexive concept further, this research is also replete with description, theories, literatures, findings, *et cetera*. Thus it is a work that refers to itself. Thus adding another layer of complexity to the concept of

reflexivity in which the discussions that follow in this research will be self-referential in nature.

The final discussions in this chapter will concentrate on identity research. The range and scope of studies of identity are legion and embrace an array of methodological positions. A range of studies is presented in this chapter that are predominantly those with social constructionism as a methodological approach.

3.5 Researching Identity

From a mental health perspective, Adams (1998) has adopted a social constructionist approach in his study of dementia care. In particular he focuses on the works of Gergen (1985) and Shotter (1993) in exploring constructions of dementia through linguistic devices in narrative and discursive accounts of sufferers and their carers. He also examines the ways in which dementia sufferers are spoken to by carers and nurses, citing the use of 'maternal' language by professional carers in particular. The notion of confabulatory story telling as a valuable means of social communication and maintaining a sense of identity for the dementia sufferer was also a salient feature of Adam's (1998) study. Wilson et al. (1998) explore the use of discursive resources utilised in the construction of people who suffer from mental illness as being dangerous. They reviewed a sample of programmes from a prime time television series to analyse how the character was being constructed in this way. Nine devices including language use and appearance combined to construct this person as dangerous. Walker (2001) in studying engineering identities

considers the construction of male and female identities in a University Engineering Department. Adopting a narrative approach to represent the voices of these students, Walker (2001) suggests that while things have radically changed for young professional women gender remains an issue. Dyck (2001) is concerned with the construction of cultural identity in Canadian health care workers. She uses narrative accounts that have embedded within them notions of 'difference', 'negotiated self' to present the students constructions of their Canadian identity. Hollander (2001) argues that that beliefs regarding vulnerability and dangerousness are constructed in conversation, as illustrated in the analysis of focus group discussions. Mullaney (2001) focuses on an interesting concept in a paper on 'never identities'. This study focuses on the construction of identity under special circumstances. The claim is made that the social construction of virgin identity is made by what they say they do not do rather than they do. Smith's (1978) study on the construction of mental illness makes use of interview data to explore how mental illness is rhetorically constructed by friends of and individuals who have a mental health problem. Similarly, Brooks et al. (1998) explore the rhetorical constructions of bulimia presented in interviews with those who have been diagnosed with this problem. The outcomes of Brooks et al.'s (1998) research identified 'victim' constructions, 'female social stereotype' constructions, 'self damaging' constructions, 'abnormal' constructions and 'personality trait' constructions. Baillie and Corrie (1996) adopt a social constructionist approach in their study on client's experiences of psychotherapy. Their research questioned how human

beings construct their reality through language use. They conclude by proposing that individuals “construct their reality by means of three distinct modes, narrative, practical action, and the multiply streams of consciousness” (Baillie and Corrie 1996, p.309).

In moving forward in this expose of identity research, it is important to include the work of some researchers who have led the field in this area. In so doing situating this research within the cadre of existing identity research. These include Widdicombe and Wooffitt’s (1995), analytic study of youth subculture; Widdicombe’s (1995) exploration of the construction of identity and it’s inter-relatedness with politics in her chapter on *Identity Politics and Talk: A Case for the Mundane and the Everyday* in Wilson and Kitzinger (1995). Wooffitt (1991, p.2), in his chapter from Gilbert’s (1993) text *Researching Social Life* informs us that “people talking to each other is so common place and taken for granted that for the majority of the twentieth century it has not been treated as a central topic in social scientific research”. In this chapter he presents an analysis of accounts, presented as “works in progress” and takes the reader through the detailed analyses of the linguistic repertoires and discursive devices used by the speakers. McKinlay and Dunnett (1998, p.48) reminds us that in adopting the notion of identity as a construct, the construction materials are those discursive accounts, such as descriptions, explanations, exonerations, corrections and reformulations, which the analyst identifies as relevant to the subject’s sense of, or display of, identity. They also caution us to be aware “that the danger lies in the apparently sensible conclusion experimentalists such as self categorisation

theorists deal with real identity, while discourse or conversation analysts do not” (McKinlay and Dunnett, 1998, p. 49). All of these authors examine how identity is constructed in conversation, as a resource for action. How it is used to perform certain actions such as justifications, excuses, blaming. The position adopted is that talk is said not because of any theoretical foundation, rather that talk occurs as a resource for action. Such is the position taken by this researcher in this Doctoral research study, where the mental health nurses talk in the focus group discussions is performative. The accounts pertaining to identities that they are providing in the focus group discussions are provided to address specific issues that arise in local contexts, that is, what they do as mental health nurses in their areas of practise. There is therefore a distinction made in the analysis of these nurses talk between what is ‘real’ and is actually ‘the case’ regarding what nurses do in practice and what is ‘taken to be real’ by the participants. It is in this latter sense that the nurses are presenting a picture of their identities at a given moment and in relationship with others. As Antaki (1994, p.51) suggests “ these participants’ purposes or reasons do not, themselves, represent transcendently real phenomena which ‘stands outside’ accounts and provide a non-discursive explanatory framework”.

3.6 Conclusion

In this chapter, it has been argued, that that from its origins as an alternative to the hegemony of the prevailing knowledge establishment to its emphasis on the social dimensions of human life, a social

constructionist approach suits mental health nursing enquiry well. As such it is an acceptable approach to adopt for this 'identity' research. Instead of emulating conventional forms of practise, and enquiry, social constructionism provides a vehicle for extending the construction of the professional identities of mental health nurses. These are constituted in the mental health nurse participants' rhetoric. Moreover, the case for researcher reflexivity has been made in this chapter in defence of its value as a means of personal development and personal growth. These discussions have also served to make a case for identity research being an important and appropriate topic for research inquiry. Discussions in the following chapter will focus on making a case for the discourse analytic approach used in this research and the use of focus groups as a medium for the production of research data.

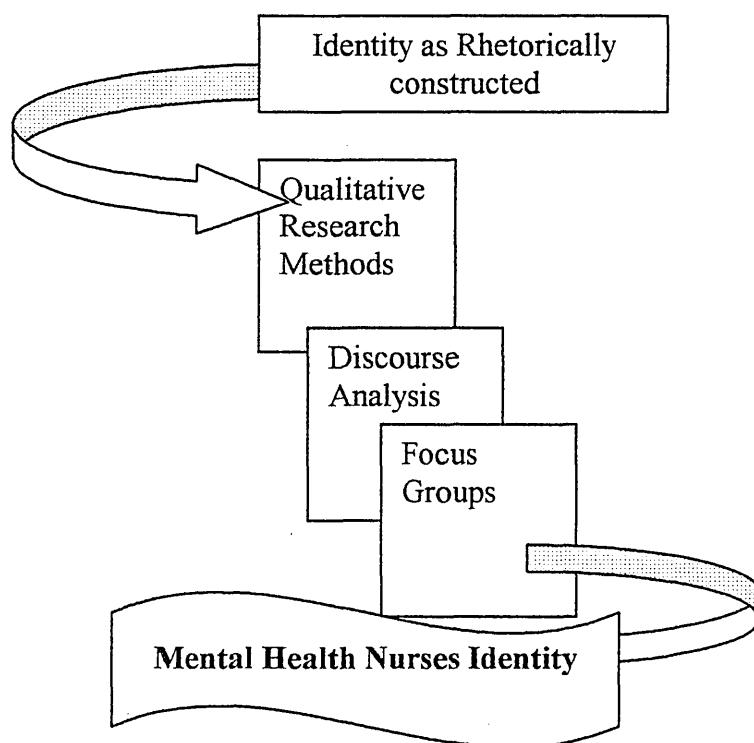
Chapter 4: Research, Discourse Analysis and Focus Groups

- 4.1 Introduction
- 4.2 Research Methods: A Brief Discussion
- 4.3 Making a Case for Discourse Analysis
- 4.4 Focus Groups
- 4.5 Conclusion

4.1 Introduction

The previous discussions have been concerned with making a case for adopting a social constructionist approach in this research study. In so doing, the researcher accepts that social constructionism is only one approach among many. To take this proposal forward, the following discussions relate to the utilisation of the discourse analytic approach adopted in this research. As such, these discussions will represent a brief debate regarding research methods in general and qualitative methods in particular. This will be followed by a more detailed look at the discourse analytic approach adopted in this research as well as the role that focus groups play in generating the necessary data for research analysis. Thus, the conceptual premise for this chapter is presented in Figure 4 below.

Figure 4: Identity as Rhetorically Constructed



4.2 Research Methods: A Brief Discussion

It is not the intention to enter into the traditional lengthy qualitative versus quantitative debate in this chapter. That is a debate that has been addressed many times and very eloquently by others and serves no meaningful purpose here. Rather, in this chapter, it is proposed that the following discussions will concentrate on exploring a range of qualitative approaches that have been commonly employed to inform nursing research. This will be followed by a discussion related to discourse analysis, with a prime focus on the rising interest in the application of discourse analysis to the study of nursing and nurse education. In so doing, the case for adopting the particular genre of discourse analysis espoused by Potter and Wetherell (1987) will be made. The researcher proposes that adopting Potter and Wetherell's (1987) approach in this research will assist in contributing to insights into the ways in which nurses' talk is functional and contributes to the construction of knowledge regarding the world of mental health nursing. In Bowers (1988) review essay, it is explained, "P&W [Potter and Wetherell] attach pre-eminent importance to language and the ways in which it 'orders our perceptions and makes things happen [and constructs] social interaction and diverse social worlds' (Bowers, p.185)".

Over the years, two apparently opposing positions have arisen in arguments that centre on mental health nursing research and research related to nurse education and practice. Those in the quantitative camp espouse experimental research where the research aims are the investigation of the outcomes of care

delivery. Qualitative researchers in opposition to this have argued for the exploration of the experiences of their research participants (Burnard and Hannigan, 2000). Thus the following discussions highlight briefly the obvious differences between the two approaches. There is then a move towards presenting a resume of the most commonly used qualitative research methods employed by nurse researchers. The final discussions in this chapter illustrate the contribution of focus group discussions to the collection of research data.

Ammon-Gaberson and Piantanida (1988) remind us of the growing interest in qualitative methods in nursing research, citing case study, grounded theory, phenomenology and ethnography as examples of approaches that lie within the post-modern qualitative tradition. They claim that “it has been our experience that novice researchers have little difficulty gathering data...Determining what it all means is the point at which the inexperienced researcher tends to get bogged down” (Ammon-Gaberson and Piantanida, p.159). In their paper *Generating Results from Qualitative Data*, they illustrate the pitfalls and safeguards of adopting qualitative approaches, emphasising the “importance of developing a line of reasoning in order to derive meaning from the data and to connect the results to a conceptual or theoretical base” Ammon-Gaberson and Piantanida (1998, p.160). The researcher proposes that one of the key differences between qualitative and quantitative methods is the construction of quantitative research’s obsession with ‘number crunching’ compared with qualitative research’s constructed focus on the spoken or written word or observed behaviour. However, it is not this alone that contributes to the distinctiveness of the different approaches. A significant and common characteristic of qualitative research is the rejection of the positive paradigm,

that is, the one single objective reality, offering in its place an attempt at representing the 'lived experiences' or multiple realities of individuals or groups. Carter (1996, p.135) describes the philosophical premise of quantitative research as being representative of 'logical positivism', in which the world is likened to a machine. From this perspective, the role of 'science' is therefore to discover the principles by which the machine, that is the world, works. This is achieved by the measurement and quantification of observable data. Carter (1996) suggests that those who are experienced in the scientific approach often carry strong pre-conceptions about the outcomes of research. Thus, they are accustomed to the process of stating a problem, developing research questions and hypotheses, testing these hypotheses and producing findings that support or otherwise these hypotheses. It would appear that there has been, for some time, a widely held, polarised vision, of these research methods. Fortunately for some of us, this limiting view is shifting. There has become a general recognition that each approach can provide valuable contributions to the investigation of phenomena significant to the topic under research (Brockopp and Hastings-Tolsma, 1995). The researcher suggests that there has been a significant shift in the willingness of researchers to transcend artificial divisions by accepting the best from both traditions. In so doing, there is recognition that both traditions provide a comprehensive 'toolkit' for the development of knowledge and understanding. For the most part, and it is the case in this research, the focus of the qualitative researcher does not lie in hypotheses testing but rather with guiding questions and research aims to their logical conclusions. Ammon-Gaberson and Piantanida (1988) claim that this presents its own problems and pitfalls in terms of data collection and

management and premature or delayed closure. These challenges have been encountered in the construction of this research, where decisions had to be made regarding the selection of the research population, the numbers of individuals who should be invited to take part in the research process and deciding when it was appropriate to conclude the study. In many qualitative studies the intent of the researcher is to understand more fully aspects of human experience as it is perceived by different observers and to communicate to others that understanding. As such, the following discussion is concerned with the use of qualitative research in general whilst at the same time making a case for the use of discourse analysis in particular.

The researcher espouses that there is a certain comfortable paradigm between nursing practice and qualitative research. Both are authored in particular ways, by that it is meant that there is recognition that humans and human realities or experiences are complex and dynamic. Firstly, they both focus at an interpersonal level, for example, nurse with patients, doctors and other nurses and the researcher with subjects and data. Secondly, that relationship is generally over a period of time, albeit that time is not constant. Although qualitative research encapsulates a number of distinctive methods, each method has certain characteristics in common with the others. Cutcliffe and Goward (2000, p.592) posit “psychiatric/mental health nurses are drawn to the qualitative paradigm as a result of the potential synchronicity and linkage that appears between the practice of mental health nursing and qualitative research”. They cite, use of self, interpersonal relationship and an ability to embrace uncertainty as elements that support this attraction. From another perspective, Day et al. (1995) remind us that student nurses are socialised into

nursing through interaction with their lecturers, in lectures and seminars and by the experience of practising nursing. Thus the importance of communication and relating at a personal level as a student nurse is also complementary to research methods that adopt similar practices. Bilton et al. (1981) classifies qualitative research into four levels of understanding, ontology, epistemology, methodology and methods. This classification is not considered to be finite, however it does present a framework within which to more easily understand these research approaches and in so doing, from which discourse analysis can be situated.

From an ontological perspective, according to Brockopp and Hastings-Tolsma (1995), phenomenology has sought to understand more about the experiences and social context in which individuals find themselves. Thus from a nursing perspective, health and illness are about individual experiences, and individual knowledge and understanding of these phenomena. This challenges the medical model theoretical perspective of health and illness that views health as the absence of illness and ill health as the presence of some biological entity that compromises wellness. Phenomenology also highlights the limits of a reductionist view of ill health that places the concept clearly within the biological sciences. Phenomenology is privileged as being the cornerstone of most qualitative research (Porter, 1996, p.115). Its application to nursing research has led nurse researchers to concentrate on individual 'lived experiences' of both nurses and patients. In recognising these 'lived experiences' an attempt is made in phenomenology to come to a deeper understanding of these experiences. There is a plethora of nursing research studies that have adopted the phenomenological approach. Chambers (1998,

p.203) sought to “explicate the core of the interpersonal nature of mental health nursing as it sits within the current political and professional paradigms”, using phenomenology as a means of achieving this. Brykczynski (1999, p.141) adopted hermeneutical phenomenology in her interpretive study of the nurse’s role in making clinical judgements. The study analysed clinical judgements made in 199 clinical situations by experienced nurses as a means of constructing a conceptual framework for nurse education and practice. In Melia’s (1998, p.27) phenomenological study of student nursing, the relationship between epistemology and ontology become clearly premised on the notion that individual lived experiences are constructions of a social reality; therefore the knowledge of that social reality will be knowledge of the individual experiences. This was achieved in her study of student nurses by allowing these student nurses to ‘tell it like it is’.

However, the researcher proposes that what these phenomenological studies appear to do, is to rummage through the layers of individual interpretations of experience and attempt to disclose that ‘experience’ as it innocently unfolds. They then seek to proceed to describe these ‘experiences’ following an ‘unpacking’ process of complex coding. The researchers justifications and explanations of each phase of the descriptive process are carefully reported. However, it is resistance to the ‘unpacking process’ that fundamentally distinguishes discourse analysis from other forms of descriptive analysis. It is suggested that when Melia (1998, p.29) states her students are ‘telling it like it is’ that may very well be the case, but with respect to Melia’s attempt at reflexivity, the end point is that it is Melia who is telling it like she thinks it is in her final analysis. Lawler (1998) presents a critique of the use of

phenomenological approaches, recognising their affinity to nursing in their existentially orientated premise but also cautioning that there are issues within phenomenology that continue to beg answers. Some of the tensions expressed in this work include

“the troublesome issues of adapting a fundamentally philosophical means of understanding human being(s) for use as a more pragmatic and robust research approach in a practice discipline; the various types of phenomenology and the confusions that surround these and other interpretive methodologies, particularly within different cultural and intellectual traditions; and the need for **nursing** to find a space in which it can give voice to aspects of its practice that are silenced in less existentially orientated methodologies”

(Lawler, 1998, p.108)

A method that is frequently confused with phenomenology is the little known research approach of phenomenography (Barnard et al. 1999, p.212). In their paper supporting this approach in nursing research, Barnard et al. (1999, p.213) highlights that despite the terms being used in the 1950s, its use as a research approach was not apparent until the 1970s. They claim that whilst both “phenomenology and phenomenography both aim to reveal human experience and awareness as an object of research, phenomenography is less interested in individual experiences than it is in emphasising collective meaning” (Barnard et al. 1999, p.213). From Barton et al’s (1999) expose of phenomenography, there appears to be a fusion in this approach between phenomenology and ethnography.

Ethnography is another qualitative approach that is frequently used in nursing research. It has its genesis in anthropology and is designed to produce cultural theory that, in turn produces insights into the ways of life of cultures or subcultures. Ethnographic data is generally analysed to explain the meaning of

behaviour in the culture, from the individual members point of view. Leners (1992) explored the phenomenon of intuition in nursing culture by sampling 40 nurses from hospital and community practice and exploring terminology, experiential knowledge of intuition, actions taken as a result of intuitive experiences and actions and feelings associated with intuitive feelings. The outcome of this research was that the nurses' intuitions were deeply connected to caring as a moral ideal of the nursing profession and a manifestation of transpersonal caring. Scott (1997, p.43) explored the concept of 'openness' in nurses' work with clients in terms of their behaviours, conversation and responsiveness to client needs. This study used participant observation and interviews to identify a range of categories as a means of describing the experiences of hospitalised patients. This work was premised on the notion that "one prerequisite of thorough nursing care is complete assessment of the patient. In order for this to occur, the patient must often disclose much personal, private information" (Scott 1997, p.43). Patients in these situations, according to Scott (1997) place great importance on the receiver of this information. In a similar vein, Ware et al.'s ethnographic study, (1999) sought to identify the interpersonal processes of giving and receiving care in a community mental health setting as a means of determining the meaning of continuity of care experienced by clients in the community. The achievement of Ware et al.'s (1999) study was gained through the identification, labelling and categorisation of observations of practice and recorded in field notes, in two community health care centres for clients with mental health problems. They conclude their research by proposing the continued benefits of ethnography as a "methodological tool" in mental health research (Ware et al.

1999, p.400). Opas (1995), in her Doctoral Thesis, used ethnographic research to explore the role of school nurses in an elementary school setting. The purpose of her research was to make visible the potential for school nurses' roles and practices. She carried out this study by collecting data in the form of field notes, transcribed interactions and interviews and written communications in a nurse's log. The result of this study identified three key themes related to the role of the school nurse, these being health care provider, educator and services administrator. Opas (1995) makes the claim that the conceptual framework underpinning ethnography and cognitive anthropology present a sound basis for exploring nurses' experiences. In Downes (1994) doctoral thesis, the professional practice of nurses in caring for individuals with aids was examined using an ethnographic approach. In her study, 25 nurses discourses were subject to a thematic analysis, the outcome being that nurses in this environment experienced a strong sense of autonomy in their care of individuals with aids, in terms of helping people 'live' with the illness and also when relevant, to die with dignity. Doyle (1999, p.29) used a similar approach in his study of mental health nurses experience of working in prison environments in Australia. They concluded that these nurses face particular challenges as a result of their work environment compared to many of their colleagues practicing elsewhere.

Whilst the discourse analytic approach used in this research embraces both ethnomethodology and conversation analysis, it is centrally concerned with the analysis of language as action rather than focusing on representations or the unpacking of language from its natural structure into concise categories. Thus it is concerned with the analysis of 'talk'. This includes the structure of

arguments, construction of justifications, and accounts. Whilst at the same time recognising the existence of the type of questions post-structuralist theory has engaged in, such as power relations and the production of knowledge. So whilst discourse analysis is closely related to ethnography it retains its own uniqueness and value as a research approach. This concept will be discussed in more detail later in this section.

The third commonly used qualitative approach is grounded theory. Grounded theory is an approach to research that has been consistently used by nurse researchers since its development. It was founded by Glaser and Strauss (1967), and further developed later by Strauss (1987). This research approach has been used to develop inductive theories on a diverse range of topics (Benton 1996, p.123). It is 'grounded' in terms of its concern with the realities of individuals as lived through their individual experiences. Theory generated from this approach is constructed from the basis of observations of the world as lived by individuals. It was primarily developed to explore questions within the discipline of sociology and is premised on the principles of symbolic interactionism. Thus its aim is to understand how groups of people define reality through their association with one another and to communicate this in the form of theory. There are similarities between the grounded theory processes and ethnography, in which field research, participant observation and interviews are key procedures. The process of coding and categorising data in grounded theory and ethnography are also relatively similar, with the grounded theory researcher using a constant comparative method of coding and categorising data and subsequently constructing theories that explain and make sense of the data. Lutzen (1998, p.101) adopted a grounded theory approach

to the study of subtle coercion in mental health practice in an attempt to determine how nurses cope with clients who do not readily comply with a nursing decision about what should be done with them. This was premised on the notion that there exists a particular client group “who cannot communicate their own wishes or needs” (Lutzen 1998, p.101). Constant comparative analysis of data was used to elucidate different types of subtle coercion in the nursing practices of ten British nurses. These were categorised as, assessing patient competency for self-choice, acting strategically, modifying the principle of autonomy, justifying strategies and reflecting ethically on actions taken. The study concluded that further research was needed and in particular questioned whether coercion could be justified as “ethically right” in some situations and not others. A similar approach was undertaken by Regan-Kubinski (1995, p.22) to determine the underlying structure of judgement tasks in clinical psychiatry. In this study, constant comparative analysis of data from thirty six interviews obtained from fifteen psychiatric nurses. The outcome being that judgement tasks were made on the basis of the “nurses perceptions of client’s presenting behaviours, with judgements being multiple, multi-dimensional, overlapping and holistic” (Kubinski, 1995, p.22). The study concludes that the understanding of judgement tasks was central to the provision of best possible care.

As previously discussed, a cautionary note should be made with regard to the place of the researcher within the research process and how the researcher’s interpretations of individual experiences can influence the outcomes of the research. Within qualitative methodologies, the role of the researcher is crucial to the research process. The researcher proposes that it is therefore

necessary to construct within these methodologies an opportunity for the researcher to openly discuss their own experiences and understanding and their potential influence on the research.

In the main, the qualitative methods discussed above share a similar epistemological perspective. That is a desire to study what human beings know to be the case and to attempt to determine how they come to know what it is they think they know and to establish criteria for evaluating that knowing. Discourse analysts according to Mills (1999, p.132) are concerned with the internal structures of interactions in their immediate context, but are not greatly concerned with relating these individual dialogues to larger social structures. As such the problems with claims to truth and meaning are not the priority of discourse analysis. She however claims that 'it is the fusion of larger social questions with smaller scale analytic questions which holds the greatest potential for future work in this field' (Mills, 1999, p.158). The researcher proposes that this research contributes to bridging that divide.

It is apparent that the opportunities open to researchers in terms of methodological approaches are extensive. It is left then to the individual researcher to make their methodological choice on the basis of what it is that they want to achieve from their research. It is from this standpoint that the following discussions are premised. As with social constructionism, the discourse analytic approach espoused by Potter and Wetherell (1987) was chosen for this research because of its appropriateness to the research topic and the discrete nursing discipline that is subsumed within that. Albeit referred to as an approach and methodology interchangeably in this thesis, it is more than this. It centres on the action orientation of language, yet is also relativist in

that the culturally available resources upon which the participants in this research employ are relevant to the practice of mental health nursing. Thus providing both methodological and theoretical direction. The following section in this chapter is presented in defence of this methodological choice.

4.3 Making a Case for Discourse Analysis

Budd and Raber (1995) propose that as a method, discourse analysis has both theoretical grounding and a record of application in such disciplines as linguistics, sociology, psychology, philosophy and communication. As such, it is well suited to the study of nurses' identities. Which itself has been perceived as multidisciplinary, embracing aspects of these and other disciplines. Indeed, Boutain (1999, p.3) takes the argument further in espousing the use of discourse analysis in nursing research from the premise that language links "history, time and people" and as such is the "starting point for inquiry about health". The particular discourse analytic approach adopted in this study illustrates how individuals use language in a particular way to make justifications and explanations of their nursing identities. In so doing claims are made with regard to the participants' professional identities as mental health nurses. As is the case with much terminology, any attempt to clearly define matters is generally determined by what they are not. The impact of this in terms of research as has been presented in the previous chapter. Therefore it is proposed that situating discourse analysis in opposition to, or indeed, in apposition to, other qualitative methods of analysis serves as a contrast structure that assists in understanding the chosen approach in this work.

The specific discourse analytic approach used in this research is ensconced within the domain of social psychology, and lies at the interface of ethnomethodology and conversation analysis. It is concerned with structural units of discourse, beyond the level of the sentence, that emerge as the nurse participants in this research engage in talking about their practice (Potter and Wetherell 1987, p.53). These interactions can be viewed as the 'axis', whereby individual nurse participants in this research engage in the process of mediating identities that serve as constructions of themselves as mental health nurses and as social beings. Discourse analysis has been placed within the modified semiological frame, commonly known as post-structuralism, which concerns itself with the underlying structure of discourse, coupled with language use and change processes. It can be categorised within the broad frame of post-modern qualitative methods that have become popular in nursing research in recent years. Cahoone (1996) cites five key themes upon which post-modernism is premised. He proposes that postmodernism typically criticizes: *presence* or presentation (versus representation and construction) (Cahoone, 1996, p.14), *origin* (versus phenomena) (Cahoone, 1996, p.14), *unity* (versus plurality) (Cahoone, 1996, p.15), and *transcendence* of norms (versus their immanence) (Cahoone, 1996, p.15). It typically offers an analysis of phenomena through constitutive otherness (Cahoone, 1996, p.19).

Discourse analysis views language as performative, rather than merely communicating what social situations are like. As such, in this research, alternative ways of knowing about mental health nursing are evidenced in the participants' talk. Language plays an important part in the construction of social situations (Potter and Wetherell, 1987; Potter, 1996). Ordinary language

is viewed as a massive reservoir of incredible variety and richness of human experience. “Just as it is difficult to imaging sophisticated communication without language, it is hard to see how complex abstract reasoning could be performed by people without language” (Potter and Wetherell, 1987, p.11). However, discourse cannot be reduced to one meaning. As a methodology, different theorists use it in a variety of ways. Mills (1977, p.26) classifies these theoretical positions into three main categories, cited as

- “1.cultural theory, critical theory and literary theory, influenced mainly by theorists such as Foucault (1970, 1980); Barthes (1986); Beneviste (1971);
2. main-stream linguistics (Brown and Yule,1983, Sinclair and Coulthard, 1975, and Carter and Simpson,1989); and
3. social psychology/critical linguistics (Potter and Wetherell, 1992, Wilkenson and Kitzinger, 1995 and Fairclough, 1992). “

Whilst recognising the individual contribution of each to the development of knowledge and understanding. The researcher proposes that it is possible for all three categories to be used interchangeably. Indeed in this research there is evidence of all three. However, in the main, this research draws upon the social psychological work of Potter and Wetherell (1987) as a methodological framework. An additional supporting rationale for this choice is that there is no one abiding discourse of mental health nurses’ identities. Rather, this research suggests that the discourses of mental health nurses exist as a result of and as part of a number of discourses, as can be seen in research studies that have adopted discourse analysis as a methodological approach. Crowe and

Alavi (1999) uses discourse analysis to examine the use of language and the reproduction of dominant belief systems in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) discourse that defines mental disorder. The study proposes that the definitions and criteria for mental disorder within the DSM-IV are based on assumptions related to productivity, unity, moderation and rationality and in so doing 'pathologises' experiences that could be regarded as responses to life events. Similarly, in examining the discourse of nursing diagnoses in nursing literature, Powers (1996) in a Foucauldian discourse analytic study claims that the discourse of nursing diagnoses is based on social notions of normality, value and expertise that effect unfounded notions of science, professionalism and social agency. Lupton and McLean (1998) in their critical discourse analytic study of Australian media representations of doctors conclude that doctors, albeit frequently under the spotlight of critical media scrutiny in Australian press, also enjoy a significant degree of social authority. In a similar media orientated research study, Hazelton (1999) analyses how mental health and illness, health policy, psychiatry and other mental health related topics are constructed and conveyed in print media in ways that serve to canvass particular current social and political discourses. Field's (1998) discursive exploration of nurses work in the hospital emergency setting examine the discourses of emergency nursing and concludes that nursing in this area is dominated by a biomedical discourse that influences nursing practice. Adams (1998) uses a discourse analytic approach in his examination of the identity constructions of people with dementia and their carers. He further proposes that such research is influential regarding the future development of dementia care nursing and policy relating

to dementia care.

There are many reasons why mental health nurse researchers should be interested in language. Language is central to all the activities mental health nurses undertake in fulfilling their roles. As such it is easy to take for granted. There are many researchers who have highlighted the importance of the use of language within this field of nursing. Bodley (1991) illustrates that reflecting on and in practice with clinical supervisors is the bedrock for quality in client care and practitioner satisfaction. The skills of self-awareness, and communication being key to the effectiveness of this model. Butterworth and Rushforth (1995) review Government recommendations that identify that working in partnership with carers and service users is key to successful mental health services. There is no doubt that this cannot be achieved in the absence of interpersonal relationships. Barker et al. (1998) in citing human needs as the proper focus of psychiatric nursing, makes a strong case for the interactive aspect of this field of nursing. In a later publication, Barker (2000) presents what he refers to as the 'Tidal Model' of care, and describes how it re-empowers people in mental distress by utilising individuals' narratives of their experience as a means of developing person-centred care plans. Another side to the value of language in nursing is presented by Berragan (1998, p.216) who reflects that one thing that "never appears to diminish is the ability, skill and enthusiasm" with which nurses tell stories about patients and experiences. In so doing, she claims that nurses are contributing to knowledge development. According to Binnie (2000), research related to nurses' use of language is vital as it is the most pervasive form of interaction between clients, other professionals, carers and other nurses. From these discussions, it can be seen

that nurses spend an inordinate amount of time talking to other people, writing reports and reading notes and case files, engaged in continuing educational activities and research. Furthermore, when issues related to the nature of the client condition and the nature of the self form part of the everyday activities of nurses it is virtually impossible to disentangle them from questions about language and its role in human affairs. Language is also central to the ways in which mental ill health and mental disorder are individually constructed by service users and their families. Language is also essential for those who make diagnoses and judgements with regard to these individuals and these conditions. As has become clear from the discussions thus far, a large part of our working activities are performed *through* language. As Potter and Wetherell (1987, p.9) point out, “our talk and writing do not live in some purely conceptual realm” they are catalysts for action. One of the major tenets of this method of discourse analysis is that individuals use their language to ‘do’ things. “Language function cannot however be understood in a mechanical way” Potter and Wetherell (1987, p.32). They suggest that it cannot be seen as a simple method of categorising speech, it depends very much on the ‘analyst’, in this case the researcher, reading the context. Gergen (1994) argues that self-narrative is a means of social accounting that is dependent on the circumstances in which talk takes place.

“ we dream in narrative, day dream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate and love by narrative”

(Gergen, 1994, p.70).

Therefore it is proposed that a ‘true’ story does not exist, since all narratives

are determined by the occasion. To presents yourself as a 'wonderful' academic for example, you would not say " I am a wonderful academic" you perhaps might modestly slip into conversation at some point that you have just had a paper accepted for publication, or had been successful in gaining substantial research funding, or had yet another conference presentation to attend. Those who are concerned with the examination of language over time identify that it exposes considerable variation. Individual accounts vary according to the purpose of the talk. That is, people's accounts vary according to their function. That is; it will vary according to the purpose served by the talk. In essence, what is happening is that individuals are using language to construct versions of their social world. As Potter and Wetherell (1987, p.33) remind us, that

“ the term 'construction' is apposite for three reasons. First it reminds us that accounts of events are built out of a variety of pre-existing linguistic resources. Second, construction implies active selection, the notion of construction emphasises the potent, consequential nature of accounts.”

They further suggest that the key challenge in analysing discourse is that the category 'analysis' itself is premised on a discourse developed for qualitative, positive methodologies such as experiments or surveys. Analysis in those contexts consist of a distinct set of procedures aggregating scores, categorising instances, performing various sorts of statistical analyses. It is tempting to think that in discourse analysis there is some analogous set of codified procedures that can be put into effect that will lead to another set of entities known as 'the findings'. The problem with most of these studies is that they tend to make the assumption that language is a window to the inner workings

of the mind. To see things in this way is misleading, although given the privilege that accrues these procedures; it is tempting to try. In discourse analysis, language use is examined as a form of 'social action' the systematic properties of which can be described and rigorously analysed. As with all scientific study of mankind, including ethnographic inquiry, the study of language advocated here has demanded the development of an 'analytic mentality' (Potter and Wetherell 1987, p. 32). The development of a repertoire of skills gained through practice, rather than through searching research textbooks is required. This research is concerned with the discursive formulations of mental health nurses identities and how they are authored into being in particular ways in relation to the social and conversational context of the focus group discussions. It is seeking to explore how these various constructions are negotiated and made to work in relation to each other. Discourse analysis is ideally suited to this as it seeks to examine how mental health nursing is constructed through social interaction. Gilbert and Mulkey (1984, p.36) view linguistic repertoires as a set of commonly used discursive devices with which people construct versions of the world for specific social purposes and in specific settings. As such, this research is not concerned with comparing a range of hypotheses but rather the exploration of constructions of professional identities that emerge from the nurses' 'discourse'. These nurses, professional identities can be found in the discourses used to identify what it is that they do in practice in focus group discussions. Therefore the richness, complexity and variability of mental health nursing as presented in the participants talk can be explored.

Fulfilling particular roles is not undertaken in a vacuum. For the mental health

nurses in this research, their “reality unfolds in relation to other people and within particular environments” (Billig 1991, p.151). What mental health nursing is and what mental health nurses do is created in interaction with other people. With this in mind, the ‘ways’ of nursing are dynamic and flexible. Undergoing shifts and turns as conversation develops. They are not simply a product or a property of one individual. Individuals, in interaction with each other jointly produce them.

As the ‘doing’ of nursing practice is central to any education and training programme, insights into this area can be used to inform and shape curriculum development. In addition to this they can advise the profession on how the mentally ill are being cared for both in institutional and non-institutional settings. Whilst it should be cautioned that the identity constructions presented in this research are identities as constructed by this group of nurses and should not be seen as a definitive ‘picture’ of nursing practice *per se*. This research is designed to be easily transferable to other professional groups in their working practices. In so doing greater clarity regarding the specific constructions of identity of a range of health care professionals can be ascertained. In a political health care world that espouses collaborative education for health care professionals, generic practitioners and integrated workforces, this would be a useful first step in the development of joint curricula and more meaningful working practices.

There are some key elements that assist the process of analysis. These include, the recognition of variability in language use (Potter and Wetherell, 1987, p.33). Within a discourse analytic framework, language is viewed as having an ‘action orientation’ (Edwards and Potter, 1992, p. 247). As a result of this, the

nurse participants' discourse in this research will exhibit a considerable degree of variability depending on what they are doing with it in relation to the discursive context. The variability will become overt in the different linguistic constructions these nurses use when performing different social actions. Variability can be used as an analytic tool at a number of different levels to help to identify the kinds of construction people use. In this study the focus could be different versions of work practices in relation to a variety of client groups, different versions of skills and knowledge needed to function as a mental health nurses and to ask what are the design features of these constructions that serve to accomplish different discursive functions. Discourse analysts do not intend to use the discourse as a route to phenomena lying 'beyond' the text. Therefore this research is not interested in underlying attitudes or dispositions. As such it is not expected that any individual's discourse will be consistent and coherent. The key is the discourse itself. How it is organised and what it is doing.

Another key point to bear in mind when analysing data is the use of commonly used discursive devices in the participant's talk. A number of discursive devices identified in studies of discourse analysis have been shown to be strategically deployed by the participants in the course of interaction in order to perform specific rhetorical functions. These devices include contrast structures (Atkinson, 1984), extreme case formulations (Pomerantz, 1986) and three part lists (Jefferson, 1991). Since the rhetorical functions to which these devices are commonly put are known, if a particular device can be identified in a text, the surrounding text can be examined for indications that the specific rhetorical function associated with the device is indeed being performed. The

following rhetorical functions have been identified: these are, to 'work up' the uniqueness and complexity of mental health nursing; to illustrate examples of knowledge and skills of mental health nurses; and to place a value on the importance of educational institutions in the development of knowledge and skills. Therefore within a stretch of text, contrast structures can be identified. This leads to the analysis of the surrounding text for signs of the actions associated with the use of this device.

A further consideration lies in the indexical and reflexive nature of language. Context has been discussed earlier in this work in relation to placing the research within the context of mental health nursing discourses and within the sphere of where and how nursing is practised. This contextualisation, albeit having value, is not the only context in which mental health nursing discourse should be considered. The meanings of words depend on their context in use. The researcher proposes that there can be no meaning for the spoken word without an understanding of the 'occasion' in which talk is used. Thus in discourse analysis, context takes on another meaning, with talk 'occasioned' in an interactive sequence. The indexical nature of talk is one of ordinary language's great strengths. In analysing data in this research, consideration is given to where and how discourse is 'occasioned' in the nurses' focus group discussions. How one stretch of text fits with what has gone before and how it builds on what comes after. Thus the nurses' discourse becomes 'reflexive' in nature. Reflexivity and indexicality are closely linked. To use Garfinkel's (1967, p.281) proposition, talk is both 'about' something as well as 'doing' something.

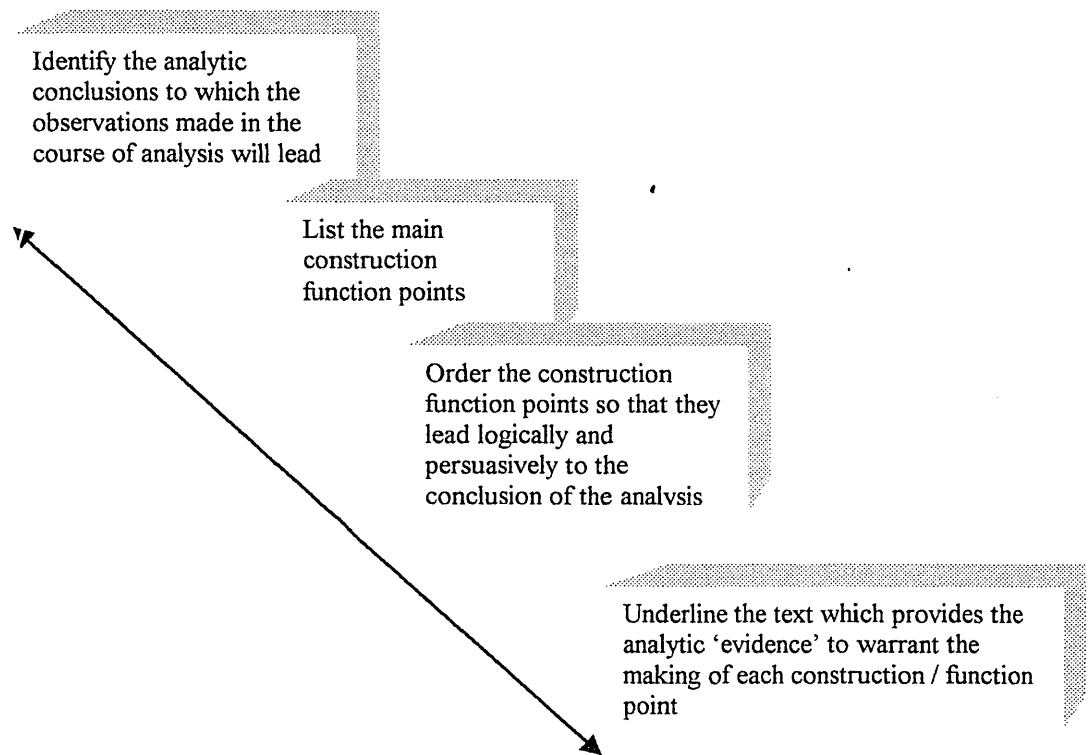
In this research, nurses are talking about nursing as well as formulating

constructions of their nursing identities through 'practice' talk. These formulations are part of the package of talk that emerges from the interactive processes in which their talk takes place. Cognisance is given to the importance of indexicality. In so doing, the nurses formulate justifications, descriptions and accounts of their role that are built up as their discourse unfolds. Thus, their discourse becomes 'action' orientated (Pomerantz, 1980). Antaki (1994, p.87) alerts us to the wider contextual concerns, which might be informing the reading of text. These may include cultural, social and political issues. For the purpose of this research, it is necessary to have background knowledge of the education and training requirements of nurses by the professional awarding body for nursing, the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC). There is also a need to be familiar with the practices of mental health nursing. As the researcher is a Registered Mental Health Nurse as well as holding a current post as Senior Lecturer in Health and Nursing, within a University which offers a range of undergraduate and post-graduate programmes in nursing, these criteria have both been met.

Finally, we should bear in mind issues related to participant accountability. In constructing versions of events, Edwards and Potter (1993) illustrate that people are responsible and accountable for the actions and events they describe in their accounts. They propose that individuals are also accountable for having produced the account and they attend to this accountability in the way that they design the account (Edwards and Potter, 1992). Speakers therefore make use of a repertoire of techniques of fact construction to ensure that what is being said is interpreted as objective. That is, emphasising that something is

really the case and is beyond being constructed as a 'reality for a purpose'. Some of these have been identified above, but others include 'systematic vagueness' (Potter and Edwards, 1990, p. 405) 'rhetoric of argument' (Potter and Wetherell 1987, p.57) and 'consensus and corroboration' (Potter and Wetherell 1987, p.86). Further discussion regarding these devices is presented in the analysis chapter in this research. As Potter and Wetherell (1987, p.64) remind us, analysing discourse is not a task that can be easily undertaken by following a set recipe. Skills are largely acquired by reflexivity in reading and re-reading the text as one tries to make sense of the transcripts. Analysis comprises two closely related phases. The search for common patterns in the data and the concern for function and consequence. The key to analysis is accepting that an individual's discourse fulfils many functions. The second stage involves determining these functions and effects and searching for linguistic evidence within the discourse. Having determined what should be looked for in analysing data in this study, the next step was to adopt a method of analysis that could be used in conjunction with reading and re-reading the data and the use of the above 'tools' of analysis. The analytic guidelines chosen for this study are those used in Cowan's (1998) unpublished Doctoral thesis. They are represented in diagrammatic form in Figure 5 and have also been used by Cowan and Leishman (1998) in a workshop on discourse analysis at a national nursing practice research conference. It seems appropriate to make use of what has been tried and proven to be successful and not to try to re-invent the wheel. Permission from the author was sought prior to the development of this study.

Fig 5 Adapted Diagrammatic representation of method of analysis.



As was the case with Cowan's (1998) work, moving back and forth between the above stages was necessary to reach the end conclusion. This was also found to be the case in the conference workshop situation (Cowan and Leishman, 1998).

In this research, data generated from focus group discussions with registered first level mental health nurses, was analysed using the above criteria. Focus groups are widely used in qualitative research and in drawing this chapter to a close, there follows a brief discussion regarding the nature of such groups and

their contribution to research processes in general.

4.4 Focus Groups

Morgan (1995) alerts us to the fact that much of our knowledge of focus groups comes from personal experience rather than systematic investigation. However, there has been a surge in the range of experiences that can be drawn from. Focus groups are group discussions organised to explore a specific set of issues. The group is 'focused' in as much as it involves a kind of collective activity. In this case the issues are related to the nurses' constructions of their professional role. Murphy et al. (1992 p.37) suggest "focus groups produce more and richer information than do individual interviews with the same number of participants". This is endorsed by Agar (1995, p.84), who espouses the claim that focus groups yield richer understandings. They are in essence social events and involve reflexive and liminal experiences and are potentially empowering to the participants. Focus groups continue to grow in popularity as a method of applied social research. Increasing attention is being given to their use as a means of obtaining qualitative data in an interactive context. "Focus groups were originally used within communication studies to explore the effects of films and television programmes, and are a popular method for assessing health education messages and examining public understanding of illness and of health behaviours" (Kitzinger 1998, p.100). It is a method of data collection frequently used in the social sciences and is of particular use in this study where the research is concerned with the negotiation and rhetorical processes within the nurse participants' talk in focus groups.

As well as the field of social sciences, there are particular advantages in the use of focus groups for researchers in areas such as healthcare, medicine and education. Barbour et al. (2000, p.83) in their paper comment on a workshop designed to allow participants the develop skills in generating data through interactive means in primary care research. Within these arenas there is an easily accessible sample population and a rich minefield of research topics awaiting investigation. The focus group method is an extremely 'user friendly' technique which does not discriminate against people who are uncomfortable with the completion of questionnaires. It can encourage participation from individuals reluctant to be interviewed on their own or who feel that their contribution is not valuable. There is a key role for the researcher in focus group discussions in keeping the interactions and discussions flowing and ensuring that everyone has an opportunity to contribute. Therefore, participants play an active role in generating discourse. Until recently much of our knowledge about the technique came from market researchers, where their use as a market research technique can be traced back to the 1920's (Basch et al., 1989). In Basch et al.'s study exploring the reasons why young drivers drink and drive, they carried out forty focus groups with 316 volunteers aged between 18 – 22 years. They adopted a "standard focus group format or group discussion, around a set of questions centres on traffic safety issues" Basch et al. (1989, p.390). They makes the point that focus groups are one way to better understand the drives and motivations of young people. The use of focus groups in contemporary qualitative research provides us with data that leads to a more in-depth understanding of the phenomena under investigation. When the goal is to generate theories or explanations, focus groups and other

qualitative methods are likely to be preferred over quantitative methods (Kitzinger, 1998, p.101). This is particularly the case in this research. It is the view of the researcher that in this instance focus groups were the most efficient and effective way of generating data that would provide richness in terms of interpretations, justifications, explanations and accounts of nurses in practice. Brown and Canter (1985, p217) suggest the advantage of focus groups can be maximised through careful attention to research design issues at both the project and the group level. There is the assumption however; that there are as many caveats applied to qualitative research in general as apply to focus groups and that in the main, most qualitative research has its basis in trust and open communication. Focus groups should not be attempted, therefore, unless the researcher demonstrates respect, regard and tolerance of the group participants.

As researcher as well as focus group facilitator, it was important to create an open and permissive atmosphere in which freedom to share points of view was encouraged. Emphasis was made regarding hearing about individual experiences, interpretations and feelings. The interface between the researcher's areas of interest and the participant's ability to discuss those areas is paramount to the success of the focus group. It is obvious that the thing that distinguishes focus groups is the interaction of the group in response to the researcher's questions.

4.5 Conclusion

This chapter presents discussions related to research in general and qualitative research in particular, as well as providing an overview of the discourse analytic approach used in this study. The chapter culminates in a résumé of the use of focus group discussions in generating data for research purposes has briefly been covered. The following chapter identifies the process of data management, sample selection other procedural research issues.

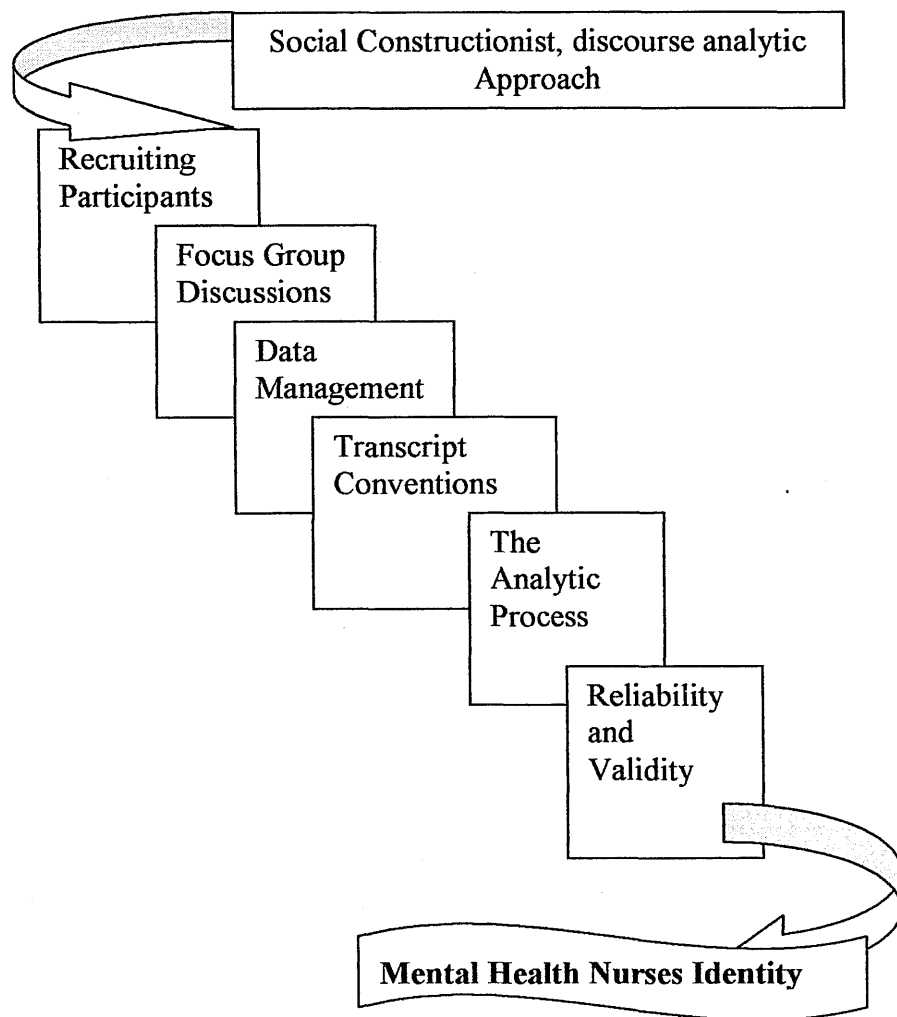
Chapter 5: Methodological Considerations

- 5.1 Introduction
- 5.2 The Participants
- 5.3 Data Management
- 5.4 The Process of Data Analysis
- 5.5 Transcription Conventions
- 5.6 Reliability and Validity
- 5.7 Conclusion

5.1 Introduction

The previous two chapters have been concerned with discussions related to the methodological and analytic choices that have been made in relation to undertaking this study. This chapter will focus on the major features of ‘how’ this kind of research was actually done’ (Psathas, 1990, p. 1). Melia (1998, p.27) highlights the notion that rhetorically, the word ‘methodological’ or study of method, should really be replaced by ‘method’, or “research procedures actually employed”. It is the latter approach that is adopted in this chapter. Consideration is given to making explicit how participants in this research were recruited, the procedures that took place in the focus group discussions and how the data generated from these focus group discussions were managed and analysed, including the use that has been made of transcript conventions. Finally, discussions relating to reliability and validity are discussed as they apply to research of this nature. Therefore, this chapter can be schematically constructed as a ‘procedural journey’ from method to analysis as seen in Figure 6 below:

Fig. 6 The research ‘procedures’ journey



5.2 The Participants

The participants in this study are drawn from registered first level mental health nurses working across a range of mental health practice areas. In selecting participants for this research, Morse's (1991, p.284) suggestion was borne in mind. She notes that the sample needs to be both appropriate and adequate. That is the choice should "fit the purpose and be able to generate sufficient quality data". In terms of appropriateness, a purposive approach to

recruiting participants was used, in which individuals who were most relevant to the topic area were targeted for the research (Brockopp and Hastings-Tolsma, 1995 p.172). In this case they were registered mental health nurses. In light of the researcher's position in Higher Education, this was a fairly easy process. Accessibility to appropriate mental health practitioners was not problematic. However from a researcher bias perspective there could be the potential for this to be an issue in research using other methodologies. As reflexivity and the role of the researcher in qualitative research has previously been discussed in this work, it is anticipated that the issue of recruiting from a readily available population in this research is an issue only for those who wish to make it so. One further important point to make at this juncture is that the methodology chosen has as its primary concern, the participant's discursive constructions of their identities, not the individual characteristics of the sample population. In the process of recruitment, a 'volunteer procedure' was adopted. In this, willing individuals were approached or were given the opportunity to approach the researcher regarding taking part in the study. Sandelowski (1986, p.77) refers to this as 'elite bias', which the researcher recognises as not applicable in this research.

Participants in this research were homogenous, in the sense that they were all registered first level mental health practitioners, currently working as practising nurses in a range of practice areas. Similar to the recruitment of these nurses, the issue of where they worked was not problematic in relation to the research topic or methodology. The prevailing rationale for this is once more, that it was the mental health nurse's discourse which was of importance, not specifically any one practice area or client group. In making the decision

to focus this research on the discursive constructions of registered mental health nurses identity, as opposed to 'all' mental health nurses, was made primarily from the premise that education and training programmes now only prepare students for this level of professional registration. This level of nurse is commonly the key population of nurses for whom most professional post registration education is targeted. It is this level of nurse in particular who are experiencing a significant shift in both educational and practice reform. However, it is acknowledged that they are only part of a nursing workforce that includes nurses who are untrained, those in training and those registered on different parts of the professional register.

In this research, the number of participants recruited to this research study is not an issue. This is premised on the fact that the methodological position is not about how many mental health nurses are saying what, but rather 'what' the mental health nurses in this study are saying. Potter and Wetherell (1987, p.161) highlight that "where discourse analysis diverges most radically from the traditional view involves the basic question of sample size", making a strong claim that the success of a discourse analytic study "is *not* in the least dependent on sample size. It is *not* the case that a larger sample necessarily indicates a more painstaking or worthwhile piece of research". As there is no discourse equivalent at present to the demanding process of data analysis required in studies such as this, Potter and Wetherell (1987, p.161) suggest that data generated from a sample of ten "might provide as much valid information as several hundred responses to a structured opinion poll". Supporting Potter and Wetherell's (1987) position, Talja (1999, p.472) suggests that the labour intensity of the process of data analysis in studies like this lends itself to small

sample size. This allowed the groups to be a manageable size for discussion. Too large a focus group can end up in people entering into sub-group discussions within the group, therefore fragmenting the group discussion. Potter and Wetherell (1987, p.161) enforce the notion that the “crucial determinant of sample size, however, must be, here as elsewhere, the specific research question”. They also remind us that some seminal work in discourse analysis was undertaken using one single text as its analytic data. Nor is it important to have the same number of individuals in each group discussion. Therefore in this research, three focus group discussions were undertaken. As the quality of the third focus group tape recording was poor, and as it was felt that there would be more than sufficient data generated from the two previous discussion groups to address the aims and objectives of this research, the first two tape-recorded group discussions were taken forward for in depth analysis.

Focus Group 1 comprised three participants from hospital based practice environments, there were to have been four, but a crisis in one of the wards required the fourth participant to withdraw at the last minute. The decision was made by both researcher and participants to continue with the discussion without the fourth member.

Focus Group 2 comprised seven individuals from a range of hospital and community clinical areas.

Focus Group 3 comprised four individuals from hospital based practice areas. Unfortunately the tape-recorded discussion of this group was extremely poor and as the individuals were from practice areas in different geographic areas, it was not possible to re-call them to repeat the process.

All participants were informed about the study, its aims and objectives and the fact that this was being undertaken as a Doctoral research dissertation. They were given a brief introduction to the research methodology, focus group discussions and their role in the research process. Finally, they were each given a copy of the focus group topic schedule, information about the approximate length of time allocated to the focus group discussion and that they would each have the opportunity both to hear the tape recordings and to view the transcribed data. One important issue that was discussed was the matter of confidentiality. All participants were reassured that their real names, and those of clinical area, colleagues, clients and others would not be used. Having addressed the issue of participant recruitment, the next stage in the 'procedural journey' is to discuss how the focus groups were operationalised. For each focus group, consideration was given regarding the venue, the time or duration of the discussion and the environment in which the discussions took place. One of the groups was undertaken in a side room of a hospital ward. This choice was made to meet the needs of the participants. The following two focus groups were held in a meeting room within the University. This again, was to accommodate the participant's needs, as they were all undertaking educational programmes at this time. In each of these settings, it was important to create an environment where there was no interruptions or disturbances. Therefore, phones were switched off for the duration of the discussions, notices put on the doors of the rooms used to indicate that there was to be no disturbance. The arrangement of the room was also key to generating an environment where participants could feel at ease in their discussions. Therefore, comfortable chairs were arranged around a small

coffee table upon which the small, discrete tape recorder was placed. The participants and the researcher sat and 'chatted' for a short time before the focus group discussions took place. This appeared to help create a more relaxed atmosphere and to allow participants to become familiar with the surroundings.

Using the topic schedule developed for this research as a guide and prompt (Potter and Wetherell, 1987, p.165), the researcher and the participants engaged in discussions, each of which lasted approximately one hour. At the end of the discussions, participants were thanked for their contributions and previous reassurances were reiterated.

Potter and Wetherell (1987, p. 165) remind us that

“interviews in discourse analysis differ from conventional interviews in three ways. First variation in response is as important as consistency. Second, techniques which allow diversity rather than those which eliminate it are emphasised, resulting in more informal conversational exchanges and, third, interviewers are seen as active participants rather than like speaking questionnaires”

Following the completion of each focus group, the researcher labelled and named the tape in readiness for processing the data. A second copy of the tapes was taken as a precautionary back up. The following section addresses the management of data in more detail.

5.3 Data Management

Porter (1996, p.333) argues that no method of data collection and management is equally suited for all purposes. One of the key features of this research involves the notion that research methods are determined by the interest and aims, the circumstances of individuals and the practical constraints faced by

the researcher. It is with this in mind that the process of data management used in this research is presented here. It is proposed that if you want to know something about people's activities, the best way of finding out is to ask them (Barker, 1996). The core value of this approach is that it allows both the interviewer and the participants to explore and clarify the rhetorical content of the questions and responses, thereby providing opportunities to encourage more detailed responses. Any confusion and misunderstandings can be dealt with immediately and there is the advantage of immediacy of response in comparison to completing questionnaires or other research procedures (Brockopp and Hastings-Tolsma, 1995, p.249). There is the added bonus that those involved are commenting on their everyday life, which is what we do as a matter of course. Thus, following the position of Potter and Wetherell (1987, p.165), transcription in full of each of the audio taped focus groups discussions was undertaken. The transcripts were returned to the participants for verification as soon as possible following transcription and each participant was given the opportunity to hear the recorded tape of their particular focus group. For two of the focus group discussions in this research, the initial data transcriptions, without the use of conventions, was undertaken by an assistant employed for this purpose. The transcriptions were checked against the individual tape-recorded discussions by the researcher, thus ensuring that no omissions were made. The transcribed scripts were read and re-read numerous times to get a 'feel' for the data as the analysis began. Along-side this, the researcher listened and re-listened to the tape recordings of the focus groups, again to get the 'feel' for the flow of conversations in these group settings. It is from this process that identity constructions become evident in the data. In the

segments of data from the transcriptions that were used for deeper analysis, further work was undertaken in terms of the application of modified transcription conventions. In applying these modified conventions, it was not felt necessary to concentrate on fine detail such as timing, intonation and inflection in this research. Potter and Wetherell (1987, p. 166) emphasise the importance of “thinking very carefully about what information is required from the transcript, and at what level the analysis will proceed”. In terms of reliability, Hayes, (1997, p.74) reminds us that the content of tape-recorded discussions can be examined more than once, thereby increasing the validity of later analysis, a position that is also espoused by Potter and Wetherell (1987, p.169). One disadvantage to this process is the lengthy transcription process (approximately eight to ten hours) for each tape. Potter and Wetherell (1987, p.166) suggest that transcription is a “constructive and conventional activity. The transcriber is struggling to make clear decisions about what is exactly said and then to present those words in a conventional orthographic system”.

The interview topic schedule (appendix i) contains prompts related to the research aims. These exist to generate discussion by the group if need be. During the interviews participants were also asked for clarification and new issues were pursued as they emerged. Hayes (1997, p.123) suggests that the interview, from a constructionist point of view can best be done if the researcher or interviewer can adopt “a stance of curiosity in which it is the understanding of the participants that is endlessly fascinating”. He claims that this approach encourages openness in the respondents and an avoidance of ‘feeding’ the answers you, as the researcher or entering into a debate with the respondents.

There is a range of opinions as to how detailed transcriptions should be. As with previous issues discussed in this chapter, the method chosen was, in the researcher's opinion, the 'best fit' to address the aims and objectives of this research and the needs of the researcher. It is proposed that the approach taken in this research has not compromised the rigour of this study. This discussion has been presented to identify the ways in which data generated from the focus group discussions were managed in a fashion that is sympathetic to the methodology and research aims of this research. The task of moving from data management to analysis is taken up in the following section.

5.4 The Process of Data Analysis

As with many of the discussions in this chapter, it is proposed that there is to-date, no right or wrong way to analyse discourse. Indeed as discourse analysis becomes more widely used, there exist as many variations on the basic concept as there are particular takes on what constitutes discourse analysis. It was suggested at the outset of this research that consideration would be given to the use of appropriate computer software to assist in the analysis of data generated by the focus group discussions. In reviewing the literature on computer analysis of qualitative data, it is apparent that there are a range of admirably suited software packages available that would assist this process without necessarily 'mechanising' the process. Indeed Tesch (1990) has produced an eloquent text that guides those of us who don't subscribe to computer analysis through the process in an extremely facilitative and informative way. Whilst the researcher remains convinced that computer analysis is useful in assisting analysis in content and thematic analysis, it became apparent as the study

unfolded that in order to gain understanding and experience in analysing discourse, this could only have been achieved by personally reading and re-reading the scripts. This decision subscribes to the views of Potter and Wetherell (1987, p.164).

Following the reading and re-reading, listening and re-listening process, the next stage in this research was to take key extracts of the transcribed tape recordings and to subject them to in-depth discourse analysis. Potter and Wetherell (1987, p.167) refer to this stage as 'coding'. However, they caution that the aim here is not to "find results, but to squeeze an unwieldy body of discourse into manageable chunks". In this case, 'coding' refers to the identity constructions that were yielded from the participants' talk. As this is not a limiting process, and is not in itself 'analytic', instances in the participants' talk that are vague or lie at the borderline of identity construction are included in this process. Each of these 'identity construction' areas is then used as analytic material and is subject to in depth discourse analysis. These extracts were then presented in their transcribed form in the analysis chapter of this research study.

Having determined what was to be analysed, the tool devised by Cowan (1996) in her doctoral research and used, in a workshop on discourse analysis at a national research conference, by Cowan and Leishman (1998) was employed. This follows Potter and Wetherell's (1987, p.168) guide to analysis as discussed in chapter 4 of this work. The use of a modified version of Jefferson's (1985) transcription conventions aided this process in terms of identifying the turns in the participants' talk, ways in which their talk is indexical and reflexive in nature and how they individually and collectively

construct identity repertoires. The Jefferson approach is further discussed in the following section. It must be pointed out that in order to analyse the data, even using the methods suggested above, it was necessary to refer continually to the tapes and transcripts throughout the process.

5.5 Transcript Conventions

As has been made clear, the transcription conventions used in this research are adapted from the system developed by Jefferson (1985, p.68). Her system uses symbols available in a standard typewriter character set to pick out features of talk that conversation analysts found important in interaction. It may be the case that to use these transcription symbols as they are applied to conversation analysis and other studies of language may be to interfere with readability of the transcripts, however, the inclusion of a modified version of this detail in the extracts used in this research, recognises it as an intrinsic component of interaction and thus a necessary inclusion in the analysis process. It provides a sense of the talk as situated, spoken and part of the construction of interaction.

The following is a summary of the symbols used in this research:

- Underlining indicates words or parts of words which are stressed by the speaker
- Colons mark the prolongation of the sound immediately before (the:n) more colons would show a longer prolongation (ye::::s)
- A full stop (.) marks completing an intonation and not necessarily a grammatical full stop
- A comma (,) marks continuing intonation not necessarily a grammatical comma
- Where one turn runs into the other with no interval this is marked by an equals symbol (=)
- A full stop in brackets (.) marks a short pause in the talk the more full stops the longer the pause (....)
- Where the transcriber is doubtful of a word it shall appear in parenthesis (role) where no guess is plausible, the parenthesis shall be left blank ()
- The code at the end of the transcript provides information on the source of the text e.g. FG1 (focus group 1),

The discussions in this chapter have presented a methodological approach that could be determined by some critiques as fairly 'loose'. Proposals have been made for an approach that embraces the notion of flexibility, freedom of interpretation and adaptability in approach. Silverman (1998, p.20) highlights the problems that are faced by qualitative researchers in terms of reliability and validity in his chapter on the Logic of Qualitative Research, by stating that "even where questions of empirical validity are taken seriously, they are not easily settled". However, Bultou and Hammersley (1996, p.295) suggest that an important aspect of validity is "that the process of data collection and analysis should be made sufficiently explicit for a reader to make a reasonable assessment of the credibility of the findings". It is suggested that this has been accomplished in this chapter and in previous discussions within this research. However, the following section will include necessary discussions

related to reliability and validation as they apply to research approaches such as the one used in this study.

5.6 Reliability and Validity

Having determined how analysis of data was undertaken, discussion on the techniques used in the validation process should now be addressed. Potter and Wetherell (1987, pp.169-171) cite four main criteria that were followed in this study:

- Coherence “a set of analytic claims should give coherence to a body of text”
- Participants’ orientation “what *they* see as consistent and different”
- New problems “discourse analysis clarifies the linguistic resources used to make things happen...[this] not only *solves* problems but creates new problems of their own”
- Fruitfulness “the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations”

Potter and Wetherell (1987, p.172) claim that these four techniques for validating findings of discourse analysis “allow for a stringent examination of any claims”. As the analytic tool used in this research and discussed earlier is premised upon these four criteria, the researcher proposes that the reliability and validity of the analytic work in this research is an ongoing and integral part of the analytic and reporting process. Thus in discourse analysis, the reliability of research results does not depend on the ‘trustworthiness’ of participant’s answers. As Silverman (1985, p.72) points out, “even a speaker who lies

applies cultural forms and interpretive resources that, in themselves, are neither true nor false, but simply exist. The foundation to this statement is that research data, in the case of discourse analysis, do not describe 'reality'. They are, rather, specimens of interpretive practices. One other key element to the 'reliability and validity' debate is that the results of the data analysis in research such as this is transparent. The reader can easily identify claims made by the researcher given that within this thesis, extensive extracts of transcribed material that has been subjected to detailed interpretation that links analytic claims to specific parts of the extracts of the scripts, are presented. As Potter and Wetherell (1987, p.172) state, "in work of this kind, the final report is a lot more than presentation of the research findings, it constitutes part of the confirmation and validation procedures itself." It does this by presenting analyses and conclusions in a form that is accessible to the reader's interpretations. This may mean that the analytic section of a discourse analytic study will be different to that of a traditional empirical report.

5.7 Conclusion

This chapter has dealt with the procedural aspects of this research. Firstly, issues related to the participants were made explicit in terms of their appropriateness regarding recruitment to this research. The second consideration was the process of data management, followed by a brief presentation of transcript convention use. This was followed by a detailed account of the process of data management. In addition to these, a brief discussion related to reliability and validity was presented.

The following chapter constitutes the analytic focus of this research. It is

constructed from the data generated by the individual focus group discussions that took place as part of the research process to illustrate the rhetorical constructions of identity within these data. There is no rationale other than ease of management and presentation to the presentation of the sequence in this chapter. The researcher proposes that there need not be a specific rationale, as each identity construction carries the same degree of relevance to the study of registered first level mental health nurses' identities.

Chapter 6: Data Analysis

6.1 Introduction

6.2 Identity Repertoires

6.2.1 Identity as Different: 'You and Me'

6.2.2 Identity as Different: 'Them and Us'

6.2.3 Identity as 'Complex'

6.2.4 Identity as 'Constructed by Others'

6.2.5 Identity as 'Custodial and Controlling'

6.2.6 Identity and 'Role'

6.2.7 Identity and 'Education'

6.2.8 Identity and 'Knowing one's self'

6.3 Conclusion

6.1 Introduction

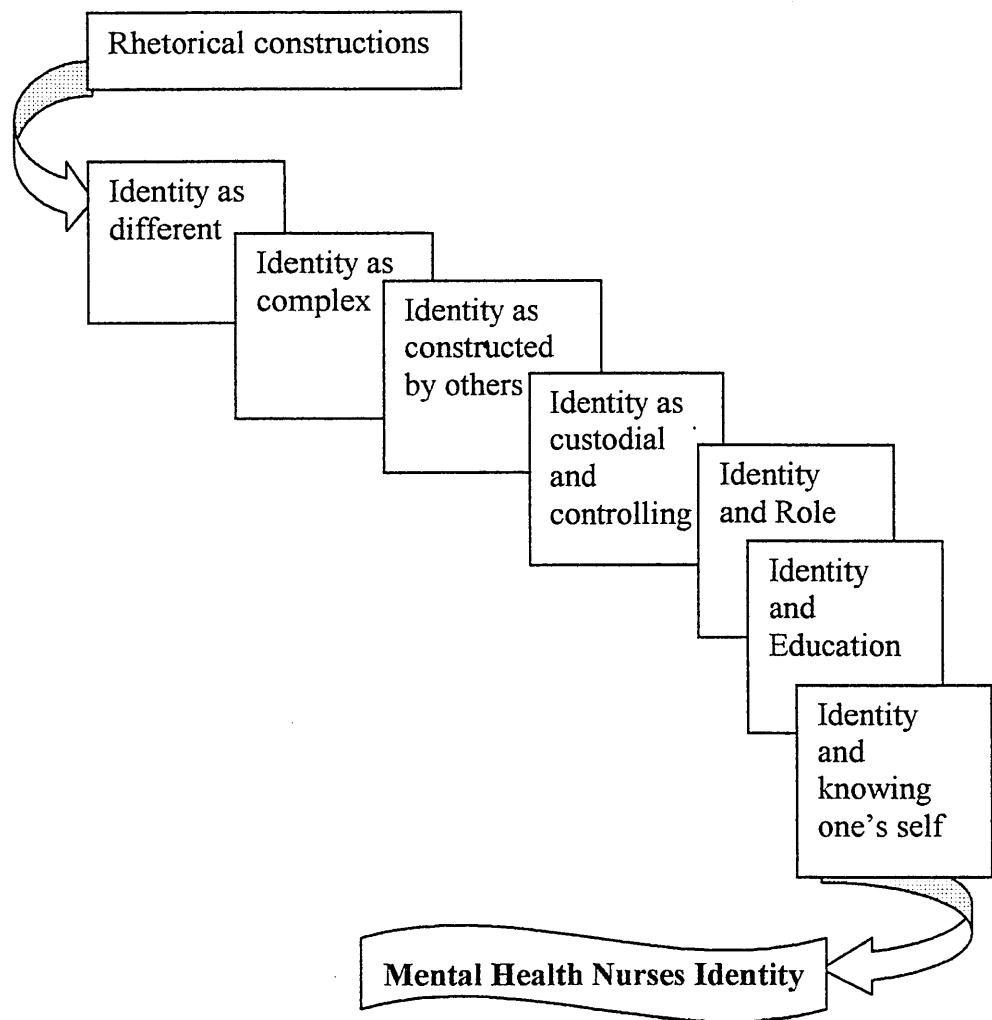
This chapter presents the analysis of data generated in the focus group discussions and follows the processes identified in the preceding chapter. It is noteworthy that there is no formal and systematic sequencing of the following analysis in relation to presentation of individual identity repertoires. This is not unusual in research of this nature. Therefore, the identity constructions are presented as they naturally occur in the researcher's reading and re-reading process.

It is also important at this point to place emphasis on the fact that the key issue in studies of this nature is the focus on rhetorical weight rather than volume in relation to the analytic process. Thus, the analysis that follows is concerned with what is said in the participants' talk rather than how many times something is said or by how many. As has been highlighted in earlier chapters there is, according to Potter and Wetherell (1987, p.161) a "danger of getting bogged down in too much data and not being able to let the linguistic detail emerge from the mountains of text".

The analytic approach focuses primarily on language use; with the empirical phenomena for consideration being the way 'identities' in the participants' talk is constructed. As the process of analysis progresses, it can be seen that the participants' constructions of their 'identity' arises from interaction with other people. These 'identity repertoires' are constructed from culturally available discourses that draw upon the participants' communication with other participants in the focus group discussions. Thus, the notion that these nurses 'do' identity is evident rather than

describe an identity that is already 'out there'. Therefore, exploration of the 'functions' served by specific discursive devices at the interpersonal level has been examined. As such, the identity constructions within participants' discourses in this research have been identified and analysed in terms of how they are found in the detail of the nurses' *talk in interaction*. The data analysis illustrates how the nurses' own identities are made relevant, as well as how they ascribe identities to others, such as client groups, other nursing groups, doctors and lecturers. As such, this research takes an 'insider' view of identity, recognising the contributions of the individual participants in its construction. It is worthy of noting that thinkers such as Bakhtin (1986, pp.259-422) argue against oral and written communication having a single voice, in favour of the notion that they draw on many tropes of social science and fact construction generally. Bakhtin's (1986) dialogic perspective follows the view that when we communicate with each other we inevitably draw from a vast and diverse repository of words that in turn are drawn from a diverse heritage and presented into an ongoing dialogue. Therefore, recognition is given in this research to the complexity of communication as the analysis attempts to "throw light on a murky topic" (Potter, 1996, p.36). Figure 7, below illustrates the rhetorical repertoires, yielded from the available data and that contribute to registered first level mental health nurse identities.

Figure 7 Identity repertoires



A sizeable proportion of the analysis chapter will be taken up with extracts from the focus group transcripts, with the remaining discussions taking the form of detailed interpretations that pick out patterns and organisations in the material. As interest in this research is centred on language use, rather than the individuals who are generating the language, and as a result of the fact that a significant array of linguistic patterns emerge

from the data, small sample sizes are perfectly adequate for investigating this important topic. For ease of analysis and 'readability' the line numbers that appear with the extracts begin and end with the presented extracts and are not numerically related to previous data in this chapter. Thus each segment of data for analysis begins with line 1 and onwards. As the full transcript of the focus group discussions are included as appendices in this research, the reader has the opportunity to read these transcripts and to establish the indexical and reflexive nature of the focus group discussion as a whole. Extracts from the focus group discussions are presented where they contribute to the logical flow of the thesis and serve to assist the analytic process. Discussions in relation to the analysis are included where it is considered to be of relevance to the identity construction. Discussions related to 'identity repertoires' as they apply to mental health nursing practice and education is introduced in the following section of this chapter. This illustrates how this 'identity' research is situated within a wider mental health nursing context. The variabilities and inconsistencies in the extracts of data are not unique to this study. These are natural phenomena of individuals' talk. The concern in this research is not with one single 'true' accurate view of mental health nurses' identity. Rather it is the versions of 'identity' generated through and by the participants' talk that is key to this research approach. Thus inconsistencies and variation is not a potential source of error, rather it is a reflection of 'normal' interactive processes.

6.2 Identity Repertoires

The corpus data is replete with contrast structures and comparative accounts that in the main serve to construct mental health nurses' identities as being 'different'. That 'difference' is in itself constructed in the ways in which the participants talk about what they do from a number of perspectives. These include making comparisons to others, what they do with and for particular client groups, what they do in comparison with each other and what they do as a reflection of a particular given legacy of 'doing' mental health nursing and the perceptions of others regarding what it is they do. They construct representations of themselves as a discrete social group, i.e. mental health nurses, within the wider social category of 'nursing'. As well as this, they construct accounts of themselves as individual mental health nurses whose role is different, within that social category of 'mental health nursing'. This is achieved through the use of descriptive accounts on 'how' and 'where' they practice and the similarities and differences in their practice. They also construct 'uniqueness' to their identity that has a historical context, including past practices, social representations of mental disorder and attitudes towards mental illness and those who work with the mentally ill. Justifications and explanations for the nature of the knowledge and skills needed to practice mental health nursing are represented by the participants in terms of their application to practice with individual clients and client groups and the

individual participants' constructions of their role as nurses. Within their discussions, the participants have made use of 'serviceable others' as a means of developing accounts and contrast structures. The term 'serviceable others' has been used by Sampson (1993, p.1226) and borrowed from Morrison's (1992) study on racism. Morrison's (1992) study identifies how several 'white' authors construct African Americans as the kind of person required for 'whites' to have the identity they wish for themselves. Similar use of serviceable others is present in the work of other researchers who are concerned with identity (MacKinnon, 1989; Holt and Silverstein, 1989). To create a 'serviceable other' is basically to accomplish the desired qualities of a particular group by contrasting with another who will be serviceable to that end. Thus, in this research, the participants make use of a range of individual and collective 'others' such as clients and client groups, other nurse groups, doctors and other mental health nurses to achieve this goal.

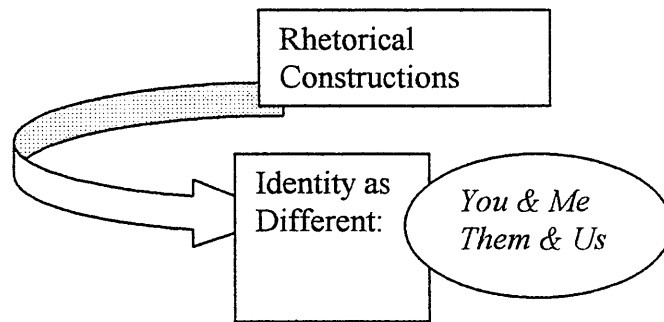
The analysis in this research serves also to examine how different discursive formulations are brought into play to accomplish actions. Rhetorical devices such as 'three part lists' (Jefferson, 1991), 'extreme case formulations' (Pomerantz, 1980), 'qualifiers' (Edwards and Potter, 1992, p. 62), 'active voicing' (Wooffitt, 1993, p.158), among others will be examined. Examples of participants' accountability within the discourse have also been identified. That is, the data has been examined for excuses and justifications of ways of practising nursing as presented by the participants as the work of (Semin & Manstead, 1983) illustrates.

Thus the linguistic repertoires in the nurses' talk in this research are presented as their version of their identities. A linguistic repertoire is a set of descriptive and referential terms that display events in a particular way. Potter and Wetherell (1987, p.149) describe repertoires as being

“constituted through a limited range of terms and used in particular stylistic and grammatical constructions. Often a repertoire will be organised around specific metaphors and figures of speech (tropes).”

The notion of linguistic repertoire is associated with the work of Gilbert and Mulkay (1984) who consider linguistic repertoires to be sets of discursive resources with which people construct their versions of the world for specific social purposes and in particular social settings. The focus of Gilbert and Mulkay's work was the study of biochemists accounts of their own work and the work of other scientists. They used several different sources of data in their analysis, interviews, research papers, letters etc. Their conclusion argues for recognition of the importance in the study of variability in language use, claiming that the biochemists portrayed their actions and accounts in a contextually appropriate way in the 'formal' and 'informal' modes of presentation of their work. Thus as Potter (1997, p.115) puts it, the biochemists “were drawing on different vocabularies or interpretive repertoires when they are describing their work”. In the analysis that follows, the linguistic repertoires of the nurse participants are presented.

6.2.1 'Identity' as different: You and me



Mental health nursing takes place in a range of care environments and with diverse client populations. In this chapter, the nurse participants' discourse is centred on the development of contrast structures and use of 'situated others' as a means of constructing their 'identity' as being different. In this research, the participants' discursively position themselves in relation to each other, their clients, other nurse groups and health care professionals.

In the extract of data from Focus Group 1 [FG1] that follows, the participants are presenting in their discussions, their interpretations of mental health nursing as practised by them. This is a response to the researcher's question during the focus group study, where they were asked to describe what they do as a mental health nurse in their own areas of practice. This extract is therefore presented as a contingent repertoire that acts as a construction of mental health nursing as being complex and different, depending on the area of psychiatry in which it is practiced. It is examined from the premise that it is simply that, a linguistic

construction that is not forced by any empirical phenomenon but rather is the contingent product of a range of extraneous factors such as interpretations of mental health clients, mental health problems and specific clinical practices. This is a particularly lengthy extract, which is not uncommon in discourse studies. It also serves as a point of reference for the reader, demonstrating the indexical and situated nature of the participants talk. There then follows analysis of sub-sections of this extract, which allows the reader to see how the analytical conclusions were derived.

Q: Describe what you do as a mental health nurse in your area of practice?

- 1.J everyone happy to talk about what we do in our own areas? =
2.M = Maybe it
3.would be a bit different between what you do in your area and what we do ours (..) there is
4.difference between the type of nursing you do and the type of nursing we do =
5.J = Just before you spoke there (..) I was thinking about (..)you know
6.(.) e:h (..)it's quite (..) new and unique (..) e:h (..) to be working as a staff nurse (..
7.and in the long term care setting (..) e:h where I am just now (..) e:h (..) I'm ve:ry
8.much aware that historically (..) the work that we do (..) that nurses (..) e:h do in
9.psychiatry is pretty much custodial (..) and I'm working alongside the legacy of
10.that to this day (...) It's awkward at times (..) and it's always ques:tioning what
11.my role is =
12.F = Have you been able to come to any conclusions about that since you
13. started up there? =
14.J = Yes and no(..) well (..) sometimes you've got to pretty much
15.Prioritise (..) you know (..) if you like things done a certain way (..) or you want a
16.care plan executed in a certain way (..) hopefully with your patient working along
17.side you (..) eh (..) it's not always the case you can do that (...). E:m (..) like I
18. say (..) you've got to prioritise (..) and get the essentials done (..) which means
19.doing a lot of non: nursing duties (...) As I see it (..) on a day to day basis (..) the
20.essentials are making sure the lads that I am in charge of (..) or (..) who are in my
21.care (..) e:h (..) make sure they are organised for the day(..) they're clean and
22.comfortable (..) they're fed and groomed (..) they can chat about any problems
23.they can see they have throughout the course of the day(..) make myself available
24.to do that (...) It's not always the case that they see that they have problems (..
25.Em (..) you know (..) we perceive they have problems (..) whereas they don't =
26.M = We
27.don't often have(..) occa:sionally we do(..) have to ensure that people get up(..)
29.get washed (..) and make sure that their physical needs are taken care of (...) If
30.they're in a condition that they can't do that for themselves (..) and need some
31.assistance for that (..) I think (..) more often the care plans don't need to take that
32. into consideration (..) the sorts of tasks you are describing(..) E:h (..) because our
33.clients are able to do these thing for themselves, em (..)so that's not going to be a
34.priority for us (..) daily (..) whereas it is with you (...) So I think that in this area
35.[acute psychiatry] the roles are very different =
36.F = Eh, em (..) it's a very much multi-
37.factorial role we have (..) and it can be different for different clients that you have
38.(..) To one client you could be something (..) to another you're quite different (..
39.So you have to be able and prepared to change your role as it's required (..) You
40.may need to take a supporting role, a problem-solving role em (..) there's lots of
41.different facets to your role (..) A lot of people we get admitted to the ward (..
42. their problems (..) if you like (..) could only be described as a situational
43.crisis(...) It's a bio-psycho-social thing (..) psychiatric nursing (..) It's not just
44.physical (..) So thei:r problems can come from an:y of those areas (..) And usually
45.it's all three (...) But it be pre:dominantly one (..) A:nd (..) let's say they have a
46.situational crisis, some sort .of stress factor in their environment that has
47.contributed to: (..) in a detrimental way (..) to their mental health (..) there you
48.would have a supportive role = (.....)
49.F = Em (..) debts (..) you know (..) money factors (..
50.getting in debt =
51.M = Relationship problems =
52.F =Relationships is usually one of the kinds
53.of things (..) You basically sit down with the client (..) and try to gain as much
54.information as possible from them (..)regarding the circumstances surrounding
55.what they see it as (..) Also (..) talk with the family(..) If there be a family (..) You
56.know (..) to gain their information as well (..)you ob:viously find that they're
57. us:ually rather different (..) you know (..) and then you just sit down and work it

58.out with the client (..) you know (..) and go through (..)you're basically there for
 59.them to talk to =
 60.M = Eh (..) eh (..) help (..) help them to suggest ways (..) or different
 61.solutions for their difficulties (..) for their problems =
 62.F =Mm (..) sometimes just
 63.sitting down with the family =
 64.M = Sometimes listening =
 65.F = With the family (..) you know (..)
 66.bringing the family together (..) Sitting there helping them (..) You know (..)a lot
 67.of them can't communicate with one another (..) just basically screaming and
 68.shouting at each other (..) and you're there just to step in if need be.
 [FG1]

At first reading this is an informative extract of data in which the complexity of mental health nursing is illustrated. J takes the lead at the outset of the discussion by asking his colleagues

1.J Everyone happy to talk about what we do in our own areas
[FG 1]

The choice of the word *happy* is interesting and could be related to his assessment of how comfortable the participants are to be involved in the research discussion. This conjures the notion that there may be some discomfort in these nurses talking about what they do in their practice with a relative stranger, in this case the researcher. We are reminded by Davies and Harre (1990) that people position themselves in discourse but they are also positioned by others and by the discourses in which they are embedded at that time. Thus “people ‘make’ discourse, but not always in discursive conditions of their choosing” (Parker 1992, p.32). So, whilst having agreed at the outset to engage themselves in this research, there is still the notion that they may be disclosing information to a stranger and, once disclosed, have no control over what happens to their discursive contributions. However, whether the participants are happy or otherwise is not taken up by the others and the discussion moves on. It is interesting to note that J is the only male in this group and at the outset, has taken a leading role in the group. This dominant approach very quickly dissipates when he confesses to being a new staff nurse, adjusting to his new role.

6.(.) e:h (..)it's quite (.) new and unique (.) e:h (.) to be working as a staff nurse (.)
[FG1]

This then allows the more experienced female nurses to proceed to dominate this particular discussion for the most part. The account as a whole presents nursing practice as being situated in the relationship the nurses have with their peers and clients as well as the context in which mental health nursing takes place, with M emphasising the fact that there is a difference by constructing nursing into different 'types'. In so doing, she also differentiates between mental health nurses who work in these different 'types' of nursing areas.

2.M = Maybe it would be a bit different
 3.between what you do in your area and what we do ours (..) there is 4.difference
 4.between the type of nursing you do and the type of nursing we do =
 [FG1]

In constructing these differences, the participants begin to reflect on their individual identities, with Jo 'always questioning' what his role is and struggling with his 'new role'.

10. that to this day (...) It's awkward at times (..) and it's always 11..ques:tioning what my role is =
 [FG1]

In making a case for contrasting identities in terms of the work of the nurses in acute wards compared to that of the nurse who works in long stay wards on the basis of the clients in acute being more able to do basic every day living tasks

26.M = We don't often have(..) occa:sionally we do(.) have to ensure that
 27.people get up(..) get washed (..) and make sure that their physical needs
 28.are taken care of (...) If they're in a condition that they can't do that for
 29.themselves (..) and need some assistance for that (..) I think (..) more often
 30.the care plans don't need to take that into consideration (..) the sorts of
 31.tasks you are describing(..) E:h (..) because our clients are able to do these
 32.thing for themselves, em (..)so that's not going to be a priority for us (..) that's
 33.daily (..) whereas it is with you (...) So I think that in this area [*acute psychiatry*] the
 34.roles are very different =
 [FG1]

She makes the case for the roles being very different (lines 27-28), using the contrasting nature of physical needs of both client groups and the task orientation mode of practice of the long stay nurse to construct these differing identities.

The indexical and reflexive nature of the discourse of F and M is evident in this stretch of text (lines 49 – 68) as they work together taking turns to keep the interaction flowing as they work up a shared identity of their role in the acute psychiatric ward.

49.F = Em (..) debts (..) you know (..) money factors (..)
 50.getting in debt =
 51.M = Relationship problems =
 52.F =Relationships is usually one of the kinds
 53.of things (..) You basically sit down with the client (..) and try to gain as much
 54.information as possible from them (..)regarding the circumstances surrounding
 55.what they see it as (..) Also (..) talk with the family(..) If there be a family (..) You
 56.know (..) to gain their information as well (..)you obviously find that they're
 57.usually rather different (..) you know (..) and then you just sit down and work it
 58.out with the client (..) you know (..) and go through (..)you're basically there for
 59.them to talk to =
 60.M = Eh (..) eh (..) help (..) help them to suggest ways (..) or different
 61.solutions for their difficulties (..) for their problems =
 62.F = Mm (..) sometimes just
 63.sitting down with the family =
 64.M = Sometimes listening =
 65.F = With the family (..) you know (..)
 66.bringing the family together (..) Sitting there helping them (..) You know (..)a lot
 67.of them can't communicate with one another (..) just basically screaming and
 68.shouting at each other (..) and you're there just to step in if need be.
 [FG1]

The complex dynamics of their role are presented in a detailed account of the client population, their debts, money problems, relationship problems is a very different picture to that of J's clients who need fed, clothes and cleaned. In his account, J describes the part he plays in meeting the basic needs of his '*lads*' with this choice of terminology providing an interesting description of the clients he works with and a context to the fundamental every day 'tasks' he is involved in. In the following small extract, the use of the word '*lads*' to describe the mental health clients being discussed by J will be examined in more depth.

19. doing a lot of non: nursing duties (...) As I see it (.) on a day to day basis (.) the
 20. essentials are making sure the lads that I am in charge of (..) or (..) who are in my
 21. care (.) e:h (.) make sure they are organised for the day(..) they're clean and
 [FG1]

In illustrating why apparently minor statements such as this are important, it is necessary to discuss some important features of describing. In examining descriptive sequences, it is important to ask why these words have been used in this specific combination. It appears fairly obvious that the description has been used because it reflects the practice situation as the participant sees it. However, as has been stated earlier in this work, language is used not only to represent but also to do specific tasks. It is also important to bear in mind that any description, no matter how sensible they may appear has been constructed from a range of possible words and phrases (Schegloff, 1972). Descriptions are produced from an inexhaustible list of possible words or phrases, each of which is potentially correct or true. How one 'describes' someone, an event or in

this case a person with a mental health problem, is in itself a construction. Potter and Wetherell (1987, p.33) inform us that a person's description will "vary according to its function" and "the feelings of the person" doing the describing. Thus the notion of 'why' and 'how' descriptions are used form part of the analysis process.

In the small extract above, the word *lads*, could easily be replaced by clients, patients, men, individuals, or people. It could also have been replaced with something less acceptable, depending on what the speaker wanted to 'do' with the description and in what context the talk took place. For example, the nurses' choice or description if he was in a pub with his friends after a busy and frustrating day on the ward may be very different. In the context in which this discussion took place however, the image invoked by the use of the term *lads* in this extract is one of individuals who need to be controlled, guided and cared for, as opposed to adult individuals who can think rationally and do things for themselves. The literal interpretation of *lads* is of young boys, young men in actual fact, the client population in this nurse's practice area is generally aged between 30 and 65 years old. The characterisation of that *I am in charge of* (line 20) and *make sure they are organised for the day* (line 21) presents a problem for the reader then in establishing if this is a construction that compounds the dominant, controlling element of the nurse's role with these *lads* as presented in this piece of data. The description presents a picture of the nurse in a patriarchal power position as in contrast to the subordinate portrayal of the *lads* who cannot assess or meet their

own needs *its not always the case that they see they have problems* (line 24-25).

24.to do that (...) It's not always the case that they see that they have problems (...)
25.Em (...) you know (...) we perceive they have problems (...) whereas they don't =
[FG1]

Or, on the other hand, presents a construction of this nurse in a maternal context, who is adopting a motherly, caring and nurturing function with those clients whom he perceives are less able to perform every-day activities. Whichever construction the reader adopts, it remains clear that there is a difference in the subject positions 'constructed between client and nurse in this data extract.

It is also conceded by J that these basic activities are essential day-to-day nurse activities in this practice area but he has made a clear distinction that they are in fact 'non-nursing' duties (line 18-19).

18. say (...) you've got to prioritise (...) and get the essentials done (...) which means
19.doing a lot of non: nursing duties (...) As I see it (...) on a day to day basis (...) the
[FG1]

This leaves the reader to establish what J's role in these activities are, if they are both essential and non nursing, and in making this statement he is constructing a registered first level nurse subject position in comparison to a person who is not a registered first level mental health nurse.

In a similar vein, the use of descriptive construction of mental health clients is also evident in a further small extract from the data where F provides a discussion on her work with her particular clients. In this extract the focus is on the change in terminology used by F when talking about her client(s), referring to them as both '*clients*' and then as '*people*'.

36.F = Eh, em (...) it's a very much multi-
37.factorial role we have (...) and it can be different for different clients that you have
38.(...) To one client you could be something (...) to another you're quite different (...)

39. So you have to be able and prepared to change your role as it's required (..) You
 40. may need to take a supporting role, a problem-solving role em (..) there's lots of
 41. different facets to your role (..) A lot of people we get admitted to the ward (..) we
 42. their problems (..) if you like (..) could only be described as a situational
 43. crisis(...) It's a bio-psycho-social thing (..) psychiatric nursing (..) It's not just
 44. physical (..) So their problems can come from any of those areas (..) And usually
 45. it's all three (..) But it be predominantly one (..) And (..) let's say they have a
 46. situational crisis, some sort of stress factor in their environment that has
 47. contributed to: (..) in a detrimental way (..) to their mental health (..) there you
 48. would have a supportive role = (.....)
 49. F = Em (..) debts (..) you know (..) money factors (..)
 50. getting in debt =
 [FG1]

In this stretch of text, F used both the term *client* and *people* in her discussion. *Client* is a fairly well used term for someone who uses services such as those provided by doctors, lawyers and nurses. It is commonly in use in health care and used in the context of F's discussion, by implication sits well with her construction of the work mental health of nurses in assisting clients, a group of users of mental health services, to resolve their problems. On the other hand, the use of the word *people*, if we are to take its literal interpretation refers to human beings as a category. Not necessarily people with problems, illness, disorder. The use of different descriptive terms in this case in some way differentiates different groups of individuals who receive mental health care. Those who are constructed as having problems who need nurses to *problem-solve and support* (line 40), and those who are constructed as those with problems that fit into a different category, *could only be described as situational crises* (lines 42-43). These are 'ordinary' people whose mental health has been affected in a *detrimental way* by 'ordinary problems' debt, money factors, and relationship problems. In this case the nurse provides a *supportive role* (line 48).

Albeit the use of description as a discursive device may be contextually varied, the procedures in their construction and management are tractable in analysis. In the examples above, the nurses use descriptive terms to illustrate their interpretation of the clients in their care, and in so doing formulate constructions of their nursing practice(s) as they engaging with these clients.

Thus the participants, in this linguistic repertoire, use clients, themselves and other nursing groups as serviceable others as a means of constructing an identity that reflects an intra-professional difference between groups of mental health nurses as well as social group difference between nurses and clients. Drawing on descriptions of every day practice that emphasise the complexity of the discipline, the participants formulate a series of contrasts between themselves as individual nurses, in which the role(s) each plays is different and dynamic depending on the area in which they work. Contrast structures regularly appear in natural language. They occur in political speeches (Atkinson, 1984), in selling techniques used by market traders (Pinch and Clark, 1986), and in accounts of mental illness, such as “K is mentally ill” (Smith, 1978). The profiles of the clients with whom they are engaged are presented as different in relation to their problems and needs, resulting in differences in nursing practices in across these care settings.

In reviewing transcripts of every day conversations, Jefferson (1991) noted that it was not uncommon for issues to be presented in three part lists. Her thesis was that these lists were generally used to summarise a particular

class of things or situations and may draw on 'list completers' such as *et cetera* or and so on (Potter 1996, p.196).

The feature of listing is frequently used in political speaking as illustrated by Atkinson (1984) in his discourse analysis of the 1983 political oratory, where he resurrects the term 'claptrap' (the trapping of applause) to characterise skilled, manipulated oratory.

Jefferson, as previously cited, has also noted that, where lists were presented in 'twos', listeners generally waited for the third component or if there were more than three items in the list, the speaker would most likely be interrupted by the listener.

Again, the extract of data for analysis here is taken from the previous large extract and is further analysed in relation to the concept of 'three partedness' as a means of illustrating the participants use of this device in their constructions of their working practices.

14.J = Yes and no(..) well (.) sometimes you've got to pretty much
15.Prioritise (.) you know (.) if you like things done a certain way (..) or you want a
16.care plan executed in a certain way (..) hopefully with your patient working along
17.side you (..) eh (..) it's not always the case you can do that (...). E:m (.) like I
18. say (..) you've got to prioritise (..) and get the essentials done (..) which means
19.doing a lot of non: nursing duties (...) As I see it (.) on a day to day basis (.) the
20.essentials are making sure the lads that I am in charge of (..) or (..) who are in my
21.care (.) e:h (.) make sure they are organised for the day(..) they're clean and
22.comfortable (.) they're fed and groomed (.) they can chat about any problems
23.they can see they have throughout the course of the day(..) make myself available
24.to do that (...) It's not always the case that they see that they have problems (..)
25.Em (..) you know (..) we perceive they have problems (..) whereas they don't =
[FG1]

In the above extract, the descriptive construction of the client has already been discussed earlier in this section. However, there are a number of other interesting inclusions in this extract. The three-part list in lines 21 – 23 formulates an account of his work with this client group. He does this by working

up a three-part list describing how these individuals are organised for the day, *they're clean and comfortable, they're fed and groomed, they can chat about any problems they can see they have*. If it were not commonly accepted that human beings engage in 'chat', it would be difficult to determine that it was people who were being discussed here. The reader could be excused for thinking that this was a discussion about dogs or horses. In the preceding lines, J sets the scene for the performance of these activities. They are *essential*; therefore this is a necessary and important aspect of the nurse's work in this area, and however they are presented as *non-nursing duties*. 'Non-nursing' assuming that they are not the sorts of activities that registered first level nurses should be involved in, and which do unqualified practitioners generally carry out. This presents a problem for the reader in terms of what constitutes nursing duties if these are 'essential' activities. It is also something that J appears to wrestle with also as in his preceding rhetoric he appears to have some dissonance regarding the practice area he is currently working in. As a discursive device, the three-part list is effective.

However, another noteworthy point in reading the data is the recurring use of words such as 'very', 'every', and 'pretty much'. These extreme case formulations are used in situations where listeners or readers of the speaker's claim(s) may undermine the legitimacy of the claim that is made. The use of extreme case formulations may be interpreted initially as simple exaggeration, with little indication that there is something systematic

in their use. However, Pomerantz (1986) analyses of extreme case formulations in every day conversation discovers that they are used by speakers to influence judgement or conclusions of those engaged in the conversation, particularly when the speaker may anticipate that the account may not be well received by others.

5.J = Just before you spoke there (.) I was thinking about (.)you know
 6.(.) e:h (..)it's quite (.) new and unique (.) e:h (.) to be working as a staff nurse (.)
 7.and in the long term care setting (.) e:h where I am just now (.) e:h (.) I'm ve:ry
 8.much aware that historically (.) the work that we do (..) that nurses (.) e:h do in
 9.psychiatry is pretty much custodial (.) and I'm working alongside the legacy of
 10.that to this day (...) It's awkward at times (.) and it's always ques:tioning what
 11.my role is =
 [FG1]

In the above extract, J assembles extreme case formulations in lines 9 and 9, *very much aware, pretty much custodial*, to formulate nursing practice in this particular area as being grounded in history. However, he makes a qualitative difference in the strength of the case in terms of his awareness of the fact and the less strong '*pretty much*' custodial activity. In making the claim to be *always questioning*, he presents a case for the dissonance that nurse vs. custodian conveys in this section, *it's awkward* (line 10).

There is further use of extreme case formulations in the following extract of discussions by M and F of their role in acute psychiatry as they construct their roles as being *very different, very much multi-factorial*. In so doing making a strong case for the construction of an identity that is different to colleagues in other areas of mental health practice.

36.F = Eh, em (..) it's a very much multi-
 37.factorial role we have (.) and it can be different for different clients that you have
 38.(..) To one client you could be something (.) to another you're quite different (..) able
 39.prepared to change your role as it's required (..) You
 40.may need to take a supporting role, a problem-solving role em (..) there's lots of
 41.different facets to your role (..) A lot of people we get admitted to the ward (..) problems
 42.their problems (.) if you like (.) could only be described as a situational
 43.crisis(...) It's a bio-psycho-social thing (.) psychiatric nursing (..) It's not just

44.physical (..) So their problems can come from any of those areas (.) And usually
 45.it's all three (...) But it be pre:dominantly one (..) And (.) let's say they have a
 [FG1]

In this section, M and F work together to construct their identity as being different to that of J who works with long stay clients. It is not merely a case that they are mental health nurses working in different wards, F takes this a step further by strongly suggesting that the role(s) is 'significantly' different. Introducing clients and their problems further strengthens the construction. Her role is *quite* different depending on which client she is working with at any given time. She then compounds the dynamic nature of her role by presenting a construction of psychiatric nursing in a multi-dimensional, *bio-psycho-social* frame, which is *not just physical* (line 43). By constructing her practice in this way, she makes a clear comparison between 'her' mental health nursing practice being different from other mental health nurse practices in other mental health areas. In this account M introduces the concepts of nurses in her area of practice making a 'supporting and problem-solving contributing' to what constitutes the 'very multi-factorial' nature of her work in this practice area.

Similar contrast structures can be seen in data from focus group 2. In the piece that follows, P talks about roles and skills being practiced in different ways across mental health practice areas. The interesting inclusion in this extract is that P makes use of 'situated others' to strengthen her case, in this instance, adult [general] nurses

1.P = could I just say that I think our
 2.roles and skills are quite personal to us (..) there doesn't seem to be a
 3.uni:for:mity to the skills we learn and practise you know. you mentioned
 4.anger management [refers to an earlier discussion](.) but you maybe do it a
 5.different way than what I do it (..) because. if you're in a more sort of (.)
 6.adult nursing (.) general nursing (..) if you're dealing with a fracture(.) or whatever
 7.(.)there is

8.a more uniformed way of dealing with that (..) I think that's where 8.psychiatric nursing is a wee: bit different(.) It's that you know: the skills we learn are 9.quite a personal thing to us (..) and you try and develop those skills to suit your 10.abilities [FG2]

This statement could be taken to imply that the roles and skills are personal to mental health nurses per se in the use of *us* in line 2. Or alternatively, and more probably given it's *occasion* in the discussion, P is using *us* (line 2) at a more personal level. However, the 'collective' *us* comes into play in the latter part of P's construction when he makes the comparison of practice between mental health nurses and adult [general] nurses (lines 6 -7). Making use of 'situated others', as a linguistic device, in an appealing way that distinguishes mental health nurses from general nurses at an application of nursing knowledge and skills level. Thus constructing a rigid, recipe following, procedural way of working, that allows for little flexibility. This way of working is presented as being the case in general nursing and is justified with an example of this application in dealing with *fractures* (line 6), where the suggestion is that there is no individual existentialist approach to the management of such an injury. In comparison, the notion that different 'ways' of 'doing' mental health nursing at an individual level, is presented in a way justifies notion that mental health nurses can be flexible in how they apply skills in different practice areas. The liberal empirical position posed by P in this section, is however couched within the use of 'qualifiers' such as *I think* (line 9), which has the discursive function: rhetorical vagueness, used when there is the possibility of anticipating possible criticism, whilst at the same time maintaining a personal legitimacy in a situation where open discussion is

encouraged.

'Qualifiers', coined as rhetorical vagueness by Edwards and Potter (1992), are generally presented in talk as a means of safeguarding the presenter from criticism or conflict if challenged on his view.

In lines 9-10, P also presents an interesting construction of skills development and acquisition. That being that mental health nurses adapt nursing skills to meet their personal abilities rather than develop abilities to meet the nursing skills.

Again this extract of data serves to construct an identity within mental health practitioners that is unique to the individual nurse in the ways that they say they use their skills in practice.

The preceding analysis has identified within the data, discursive repertoires of identity that rhetorically construct these nurses as being 'different from each other'. They have achieved this by presenting accounts of their practice and making rhetorical contrast structures between and among each other. In the following piece of data analysis, contrast structures are developed in the nurses talk that place them in a position of having an identity that is 'different' from other nurse colleagues and health care professionals.

6.2.2 'Identity' as different: Them and Us

The notion of categorisation is an important and central component of people's talk. We all populate our lives with a range of different categories

of people who are described and understood in relation to their unique biography, such as friend, employer, introverts, foreigners, and many more. In the world of nursing these categories may include other health care professionals, such as doctors, social workers, other nurse groups as well as patients. In constructing an identity that is 'different' between themselves as mental health nurses and between themselves and other social groups, the nurses in this research have rhetorically placed themselves in a particular "category membership" to use Potter and Wetherell's (1987, p.116) terminology, by working up contrast structures in their talk in order to achieve a particular goal, such as justification or explanation. The analysis that follows explores accounts from the data that are constructed to persuade the receiver that mental health nurses are a particular 'category' of health care professional. In the extract below, this is specifically constructed to make a distinct contrast between mental health nursing practice and adult [general] nursing practice. Within the construction, F and M uses the use of metaphors, extreme case formulations and lists to make a persuasive case for this difference in practice between the two groups of nurses

1. F = I
2. think the gen:eral nurse may (..) take a tray with a dress:ing on it to a bed (..)
3. and that's their in:strument of care (....) the in:strument of ca:re we have is
4. ve:ry much ourselves in re:lationship to (..) in our re:lationship with the client
5. (...) all the different ha:ts we wear (..) all these di:fferent things we do: for
6. them (..) is based on that relation:ship(.....) and that is ou:r e:quivalent to the
7. sph:ig or the dress:ing (..) we:'re the tran:sport for the person (..) that is (..) tha:t
8. makes the difference for them (..) and that's why it's rea:lly im:portant that we::
9. know what we're do:ing (..) and we: take that re:spon:sibility ser:iously (..)
10. because e:very word you say to some:one can have an effect on them (..) so
11. you:'ve got to be =
12. = because we:'re not actu:ally do:ing things hands on we're seen
13. some:times as not doing any:thing =
15. J = But we:'re say:ing things hands on (..) if you
16. like=
17. M =because we:'re not actu:ally
18. apply:ing

a bandage or putting in a needle (..) or (..) eh (..) doing things like
 19.that (..) you know (..) they say 'what is it you do with them ?'=
 20.J = it's im:portant
 21.then for us to (..) convey: the impo:rtance of the therapeutic use of self to our =
 [FG1]

Throughout the analytic process, the following questions were asked by the researcher. What are the participants 'doing' with their talk? What are they attempting to achieve in these constructions? And 'how' are they doing it? What are the construction functions that are being mobilised by participants to build up identity constructions?

F has distinctly separated mental health nursing and adult [general] nursing in a very interesting way in this piece of discourse. They have presented an argument in which general nursing is constructed as 'depersonalised'. This is done in the choice of metaphors used to construct general nursing practice. While at the same time mental health nursing is clearly categorised in a 'person centred' domain.

F begins the categorisation process in line 2 when she makes use of the *tray and dressing* metaphor as being the general nurse's *instrument of care*. The depersonalisation of the work general nurses do is further compounded by the use of more inanimate objects as instruments of care *the sphig or the dressing* (line 7) and the bandage and needle (line 18). The participants do not use any term that refers to the general nurse applying or doing anything with these things with 'people'. Indeed, M makes the case for taking the tray with the dressing on it to the *bed* (line 2). Albeit M alludes to doing 'something' with the bandage, *applying*, and the needle, *putting it in*, in line 18, but does not take this further and personalise

this act, rather it is left to the listener or reader to do with this what they will. If one were completely alien to the culture, one could be left thinking that the procedure was being carried out on the bed. This operates in contrast to the participant's construction of mental health nursing. In the above extract of data, they work up a strong case for a 'people centred' construction of mental health nursing by emphasising the low visibility, interpersonal skills they employ in their area of practice.

2.the general nurse may (...) take a tray with a dress:ing on it to a bed (...) and that's
 3.their in:strument of care (...) the in:strument of ca:re we have is ve:ry much
 4.ourselves in re:la:tionship to (...) in our re:la:tionship with the client (...) all the
 [FG1]

There is a powerful contrast between the use by general nurses of medical equipment as their 'tools of the trade' and the therapeutic use of self espoused by the mental health nurse in this extract. M argues strongly that the *instrument of care* in mental health nursing is *very much ourselves* (line 3 and 4) and not only are the nurses the agents of care, that care is client centred, based on the relationship between nurse and client (lines 5 –6).

3.their in:strument of care (...) the in:strument of ca:re we have is ve:ry much
 4.ourselves in re:la:tionship to (...) in our re:la:tionship with the client (...) all the
 5.different ha:ts we wear (...) all these di:fferent things we do: for them (...) is based on
 6. that re:la:tio:n:ship(.....) and that is ou:r e:quivalent to the sph:ig or the dress:ing (...)
 [FG1]

M makes use of extreme case formulations such as *very much* (line 3), *all* the hats (line 5) *all* these different things (line5) in emphasising the importance of working in relationship with *them* (line 5) and whilst there is no identification of who is referred to the use of the word *them* suggests a people centred practice.

Potter and Wetherell (1987, p.137) do suggest that in discourse analytic

work, “Many different studies have shown that categories are selected and formulated in such a way that their specific features help achieve an important goal”. In this research, they serve to illustrate the building blocks of mental health nurse identity, which is rhetorically constructed. Indeed, Billig et al. (1988, p.121) espouse “we do not stand back from life, pinning causes on events and judgements on actors, but we are involved in life, arguing, disputing and being perplexed about what goes on in the world”. They further suggest that if “one is interested in the way people think about the world, attention must be paid to the language they use to talk about and describe social life”.

The preceding analysis has examined how mental health nurses make a case for differences between nursing groups, in the following extract of data the categorisation construction is used to represent differences between categories of health care professionals, in this instance, the experiences of the mental health nurse participants and their construction of the nurse, doctor relationship.

The participants’ discourse in the following extract of data make claims regarding the relationship between doctors and nurses.

- 1.Prue = I trained the old training (..) We were talking about this this
- 2.morning (..) and coming back through the P 2000 [contemporary nurse
- 3.education scheme] oh (..) huge difference (..) absolutely enormous (..) I
- 4.remember the last time (..) I mean I still get mocked for this at work (..) a
- 5.doctor walks in (..) we have a consultant just now that does intimidate me (..) and
- 6.and she’ll walk in and my heels click (..) and my shoulders are back (..) and I
- 7.notice students who are very good and they’re not inappropriate (..) but I’ve
- 8.noticed that they’re much more relaxed than I am, but I think that’s the old
- 9.medical=
10. Sue =Is that not a
- 11.positive thing that we’ve actually=
- 12.Prue =Very (..) don’t get me wrong=
- 13.Sue =the horrific hierarchical

14.structure and=
 15.Lu =I enjoy having the knowledge now to be able to challenge (..) I
 16. think that was the one thing that I felt I lacked=
 17.Sue =Five years ago you didn't
 18.even challenge (..) when you think about it=
 [FG2]

In the above extract, the experience and relationship Prue has with the consultant with whom she works is interesting from a number of perspectives. It is interesting to note her justification for her feelings and expressed behaviour is placed in the context of her previous experience in nurse training [which, along with the others in this particular group, occurred some time ago] (lines 1-2). The comparison she makes, using extreme case formulations such as *huge difference* and *absolutely enormous* (line3-4) graphically depict the change in 'ways' of nursing education and training over time and reflecting the *horrific hierarchical* nature of the health care professions (line 3).

In the short piece of data above, Prue provides her account of the extreme nature of the nurse/doctor encounter, using phrases like *heels click* and *shoulders back* (line 6) which are frequently associated with military behaviour required to address meeting a more senior ranking officer in a subordinate versus authoritarian manner. This account presents a power difference between nurses and doctors, which as is evidenced in this piece appears to be shifting with time and new ways of preparing nurses for their role, (lines 17-18) *five years ago you didn't even challenge*. She strengthens the case for this 'old way' of behaving in line 3 where she is *mocked* for standing to attention when the doctor comes on the scene.

Albeit Lu presents a piece that gives an account of a shift in her ways of working with medical staff in the following extract with the notion that ‘gaining knowledge’ being used as a powerful contribution to these changing practices.

- However, in the following extract of data, Saul constructs the concept of the doctor in his practice area being privileged with the ability to *empower* (line 1) the nurse and facilitating this process by being *willing to listen* (lines 1-2) and *support* the nurse (line 3). The powerful use of the three-part list he *made you, he empowered you, he supported you* (lines 3-4) placing the doctor in an omnipotent position over the nurse who is presented as being *fortunate* (line 1) in having had this experience.

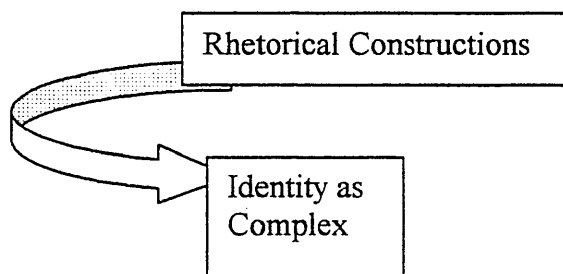
- The use of justifications in discourse serves to make the claim that certain actions are indeed good, sensible and permissible under the circumstances. They sit in both apposition to and opposition to excuses as

a means of providing an acceptable account. Thus, they have the same rhetorical value. That is, they contribute to the discursive toolkit as equals; whilst at the same time 'do' different things within discourse. The theorist most associated with the study of excuses and accounts include Austin (1962) whose contribution is the clear distinction he made between justifications and excuses. In this analysis, the participants' use of justifications and excuses as a rhetorical device to assist in constructing identity repertoires is evident in their accounts of working with each other, in comparison to others and alongside medical colleagues.

These differences having been worked up in the mobilisation of identity constructing rhetorical devices within the participants' discourse. Thus, it is apparent at this point in this research study, that the participants have worked up constructions of their identity as mental health nurses in their accounts and descriptions of their work in practice and in the use of discursive devices that facilitates identity construction in relation to each other

The following analysis is concerned with identity repertoires that situate mental health nursing identity as complex. The data has a number of interesting rhetorical constructions that serve to make claims for this. As with the previous analysis, extracts have been selected by the researcher from the corpus data and are presented in this chapter for analytic consideration. The lines of the data extracts are again numbered for ease of reference, from the first through to the end line, sequentially as they appear in this section.

6.2.3 'Identity' as Complex



The interesting discursive starting point to this repertoire is the agreement by M and F on the notion that defining mental health nursing from an observational perspective is hard to do.

- 1.M I think people think mental health nursing is difficult to define because
2.they think we don't do anything =
3.F = exactly
4..M when you start trying to look at all the different things we do and then
5.define that in simple terms its...
6.J Should we have to define it ?
7.F I think we do..we have to justify it..very much so
[FG1]

The short extract of text above presents an interesting starting point for analysis, and discursively situates this research as being important for the participants to move on and discuss further their 'identity'. The participants raise six key points within this extract that justify an attempt to explore further what it is that mental health nursing is about. The first is M's open line that she is thinking about what others are thinking and what they are thinking is that *mental health nursing is difficult to define* (line 1). The second is the notion that these others, 'people', have a particular position regarding mental health nursing, that being, that they

(line 2) *think we don't do anything*. The third is that the participants are beginning the process of collectively subscribing to the notion that mental health nurses *do a lot* and in so doing, all the things that mental health nurses do presents a problem for easy definition. The fourth, and perhaps most interesting is the collectiveness with which the participants agree that they do they *need to define* clearly what it is they do. The extreme response from F is a reasoned route towards a clear yes, *very much so* (lines 4-7).

Looking for 'identity repertoires' that had 'identity as complex' as a key feature of their structure was the starting point of this analysis. The preceding extract providing the justification by the participants that it is an important thing to do.

In the extract of text that follows, F presents a representation of the role of mental health nurses as being a complex phenomenon with many dimensions and *aspects* (line 1). The main discursive construction function point being that mental health nurses have a *multi-factorial* role, that is, one that is influenced by many factors. In this case, the participants bring the clients into the discussion, focusing on their individual and collective needs, and the nature of their presenting problems. This use of 'situated others' has been constant throughout the participants discourse. Examples of the complex concept of mental health nurse role are offered (lines 3-5).

Mental health nurses are constructed as being people who are responsive to dynamic shifts in practice situations and who need a broad range of knowledge

and skills that encompasses social issues, knowledge of physical and psychological health issues in order to work with their clients this is justified in the representation of mental health nursing being *bio-psycho-social* (line 8) and not merely limited to *physical* health issues (line 9).

The clients are presented as individuals whose problems are complex and multi-dimensional and a result of their particular social environment. This case is made by using extreme case formulations, *very* (line 1) *totally different* (line 3).

M takes this up and provides an example of the client population she works with as an account that supports the complex nature of the work of mental health nurses and the diversity of needs of her clients. She presents a picture of clients who do not fit neatly into the medical diagnoses model suggesting that their *problem* is socially constructed rather than medically determined, citing it as *situational crises* (line 7-8).

1.F = eh (..) mm (..) it's a very multi-factorial role we have (..)and it can be
2.different for different clients that you have. To one client you can be something
3.to another you're totally different. So you have to be able and prepared to
4.change your role as it's required (..) you may need to take a supporting role; a
5.problem..solving role (..) em (..) there's lots of different aspects to your role=
6.M =a lot of
7.people we get admitted to the ward, their problem if you like (..) could only be
8.described as a situational crises(..) it's a bio-psycho-social thing psychiatric
9.nursing (..) and it's not just physical (..) so their problems can come into any of
10.those areas (..) and it's usually all three (..) but it can be predominantly in one
11.(..) and let's say they have a situational crisis (..) some sort of stress factor in
12.their environment*that has contributed to (..) in a detrimental way to their
13.mental health (..) there you would have a supportive role=
[FG1]

The above extract of text also illustrates how this complex role is 'operationalised' by the participants. They offer a version of mental health nurses having to be both *able and prepared* to adapt their role depending on individual clients needs (line 2-3), suggesting that the

nurses need to have 'what it takes' to fulfil these requirements, that is, the ability to carry out their role. This concept enhances the notion of complexity. The nurse in this construction, having to have multiple identities depending on which client she is engaged with, therefore proposes that there is no universal 'nurse' construction.

However, the term *able and prepared* (line 3) is also presented here, which may suggest the existence of some prior education and training for their role or could be equally be construed as being willing to carry out these multiple role positions.

The above extract also presents an interesting example of categorisation (Edwards 1997, p.202) for both the mental health nurse, who has *lots of* different aspects to her role (line 5), and the client with mental health problems, *lots of* whom (line 6) have crises of the nature described in the extract.

Presenting mental health nursing in this way, makes use of categorical categories that embrace classical, natural and discursive verbal categories. The commonly understood categorical definition of mental health nursing as *bio-psycho-social* (line 8) serves to include all forms of mental health nursing and exclude any other nursing disciplines, such as adult [general] nursing. This example sits in analogy with Plato's categorisation of humans as 'featherless bipeds' as a classical category where there is meant to be clear boundaries, expressed in technical terms, that refers to something that is 'ideal' (Edwards, 1997, p.203).

The bio-psycho-social model of mental health is a commonly used resource in nurse education and practice that provides a framework for curriculum delivery of a range of aspects related to mental health practice. But to accept or reject it, one is obliged to understand the technical

reference terms it employs, such as biological, physical and social aspects of mental health and mental health practice. It also begs an understanding of the symbiosis and synergy these three elements have with each other as they relate to mental health and mental health practice. And additionally requires an understanding of opposing models of reference as a means of determining acceptance or rejection.

The phrase, *it's not just physical* in line 9 presents a notion that mental health nursing is an activity in which nurses engage in more than 'hands-on' work with clients which is a commonly understood classification of a nurse. 'Doing things for' patients are a 'natural categorisation' in which nurses are defined in a 'functional' sense as the providers of care.

11.(..) and let's say they have a situational crisis (..) some sort of stress factor in
12.their environment that has contributed to (..) in a detrimental way to their
13.mental health (..) there you would have a supportive role=
[FG1]

In this the above piece, a less clearly defined discursive representation of mental health nursing is presented that leaves open to interpretation just exactly what *situational crisis* and *sort of stress factor* might be. However, it is given significant import by M where she works up a discursive repertoire that claims that not just some people but a *lot* of people who are admitted to her area, not just have, but *could only be described* (line 11-13) as *situational crisis*. Interesting in taking away the personal element in this representation, M subscribes a medical model, diagnosis terminology.

In the above discussions, I have sought to illustrate how verbal categories are

discursive resources with which the participants in this research perform action, not simply the way they see things or the way things are. The action being performed is the construction of mental health nursing as complex and *multi-factorial*. In developing this 'mental health nursing is complex, 'identity' repertoire', the participants have created a contextual springboard from which further specific repertoires related to the complex identity repertoire can be presented.

In the following stretch of text, J presents an account of his transition from student to *new* staff nurse role. He does this by presenting a contrast structure between his client group and his particular area of practice and that of the other participants in this focus group *the girls* who work in acute psychiatry (lines 1-4). He focuses on the *easing* in to the role and the gradual 'getting to know' the clients he works with in comparison to the presentation of a more immediate need to make holistic assessments of clients undertaken by the acute psychiatry nurses. Thus, for J ward administration is presented as key and getting to know the clients can be achieved over time. Thus reflecting the differences in nature of the two client groups in a way that appeals to 'shared knowledge' by the participants of both these care settings and the different client groups.

However, in gradually getting to know his *lads*, he also appears to be gaining 'holistic' insights into the effects of their mental health problems on different aspects of their lives (lines 7-9). His clients are presented as being *grossly thought disordered and pre-occupied by psychotic thought* (lines 9-10)

and he uses an extreme case formulation to present a case for the impact this has on these clients ability to communicate, that is a *fundamental breakdown* in communication (line 12).

1.J=In the area I work in I've been able to ease myself into the role (..) because
2.(..)eh (..) unlike the acute ward here where the girls are, they've to try and
3.obtain a (..)holistic picture of their client within a very short space of time (..)
4.whereas I see myself (..) when I first started as a staff nurse in the long term ward (..) I
5.had to learn a lot of administrative duties immediately and (..) I took a wee bit more
6.time to get to know the lads (..) you know(..) that I look after(..)and you know their
7.families and so forth (..) em (..) so it's pretty much different (..) the majority of our
8.lads (..) they're grossly thought disordered (..)constantly (..) apparently preoccupied
9.by psych:otic thought of one kind or another and (..) that appears to lead (..) eh
10.(..) to (..) you know (..) a breakdown in their functioning on a day to day basis (..) a
11.fundamental inability to communicate with peers or staff and there are other areas (..)
12.eh (..) that you can observe areas in their life that are being neglected(..)
13.appearance(..)self care(..)em(..)their relationships break down(..)or non formation of
14..relationships
[FG1]

Another interesting feature of the above extract of data is the use of linguistic devices such as deixis and anaphora, that when used reflexively and indexically in discourse shifts their meaning according to context (Hanks, 1992).

In the above extract J refers to *the girls* (line 2) and *the lads* (line 6), both nouns referring to young women and young men respectively. However, that is where the similarity ends within the context of these discussions. The girls that J refers to are his fellow professional colleagues and the lads refer to the client group with whom he works. The point here is that each of these descriptions is packaging the 'sense' of events and provides a context for each other. It also assumes a 'shared knowing' or 'common ground' between and among the participants of the interaction. There is a 'chummy' use of the term *girls* for his female colleagues, which is accepted

by them. This reflects the relaxed and comfortable relationship between this small group of mental health nurses.

This is augmented by J's use of *you know* as an appeal to shared knowing among the participants. (lines 6 and 10).

As Edwards (1997, p.137) suggests,

“not only is the nature of shared knowledge a practical matter managed in discourse, but the details of that management are also performative of a range of social and rhetorical devices”

The appeal to ‘shared cultural knowing’ is frequently employed throughout the participants discourse in this research and encompasses fundamental things such as ‘the world of mental health nursing’ to more local knowledge related to routine practices, commonly used jargon, familiar places.

In the analysis that follows, the notion of ‘shared knowing’ remains constant in the participants’ use of commonly used terms that describe the various roles that are presented and in the reflexive and indexical way in which the discourse flows between the participants. In this rather large extract of data, the participants individually and collectively subscribe to the discursive construction an ‘identity’ repertoire that encompasses multiple roles that they present as being aspects of their work as mental health nurses.

The descriptive ‘talk’ presented in the participants discourse opens up the possibility of looking to see what is being achieved by the participants in describing these roles in particular ways. It is about how the participants rhetorically construct these roles in discursive ‘social action’ that is, in presenting

accounts of their practice that contributes to the 'identity construction'.

Edwards (1997, p.8) suggests that "one of the important features of descriptions is their could-have-been-otherwise quality", emphasising that "no description of anything is the only one that is reasonable or possible"

The extract of data that follows is again rather lengthy. This serves to illustrate to the reader how constructions are formulated indexically and reflexively. It also, as has been stated, offers the reader the opportunity to see how the researcher has applied the analytic process. Smaller extracts from this section will be subject to further analytic scrutiny as the analysis process moves forward

- 1.J.In every aspect of my. job (..) I see myself very much as an advocate(..)
2.eh (..) whether it's within dealing with family(..) eh (..) medical staff (..)
3.anyone (..) basically acting on behalf of your patient or client (..) hopefully in
4.collaboration with (..) eh (..) but a lot of time (..) eh (..) the men in our ward
5.(..) eh (..) they're unable to formulate opinions or ideas or express their needs
6.or wishes adequately so they have to a greater extent (..) eh (..) learned to rely
7.on staff to do that for them that may be institutionalisation (..) I'm sure it is as a
8.matter of fact (..)=
- 9.M. =Patient advocate is one of the important roles I think (..) you
10.can take that role on board (..) I don't think we're always aware we're doing
11.it (..) I certainly do (..) making phone calls (..) appointments (..) all sorts of
12.things on people's behalf (..) you (..) we're meant to know (..) we're meant
13.to know everybody's (..)=
- 14.F = Yes (...) we're meant to know everybody's
15.resources eh (..) allowances (..) yes (..) you'd be amazed at what we're
16.expected to know(..) so we're very much patient advocates and again
17.relaying it at consultant's meetings and the doctor will say and what do the
18.nurses think (..) what's the nursing staff opinion on this so again you're
19.relaying a nursing opinion to the medical staff (..) I think the patient sees us
20.often (..) eh (..) with the key worker system as their particular nurse and
21.you're someone to talk to someone who'll listen to them (..) if they've got a
22.problem your the person who they can bring that problem to (..) resolve it (..)
23.so you're a counsellor (..) yeah (..) I think =
- 24.J =(..)eh(..) every day has been a different experience for me (..)
25.how could I put it (..) eh (..) it's been fantastic working in the long term (..)
26.eh (..)care setting because every day has been (..)has been like a different
27.play (..) a different play every day (..) and never a dull moment (..) so you've
28.got to put on different hats in accordance with which scene is being played
29.on that day (..) y'know =
- 30.M. =yeah...Sometimes we are custodians (..) you may have to detain
31.somebody under the nurse's holding power(..) or detain somebody under the
32.Mental Health Act (..) your job is then to observe them to make sure they're
33.still on the ward (..) to keep them on the ward if they're attempting to leave
34.and then so (..) you're looking at the priority being the patient's safety (..)
35.that's your priority (..) to keep them safe (..) so in that way you're taking

36. over part of their personal responsibility to an extent you may be infringing
 37. on their rights but you're weighing it up all the time to do (..) you're weighing
 38. it up (..) you're weighing it up every 24 hours if somebody's going onto obs
 39. (..) you're looking at it every hour (..) do we still need to be doing this ? (..) because it is an infringement on their rights but you're always weighing up
 40. the patients safety I think that's an important part of the role because it is an
 41. infringement of their rights = [FG1]

The case made by J for the importance and significance of advocacy in mental health nursing practice is presented in the powerful statement in line 1.


1. J. In every aspect of my job (..) I see myself very much as an advocate(..)

In this small extract, J clearly presents the notion that this activity is a major element of his practice as a mental health nurse. The extreme case formulations used, affirm the robustness of the case he makes, *every aspect* of his job and *very much* an advocate. He then moves to present a case for the statement made by providing examples of *aspects of his job*. The impact of the diverse nature of his job is presented in line 2, we can accept as a commonly held view that nurses deal with families and doctors, but here J expands this sphere of contact to include *anyone*. This inclusion assists in building up 'advocacy' as an important aspect of his role.

He then moves towards an account of advocacy as he sees it and the ways in which he 'operationalises' this role (lines 10-13). In the above extract he presents a functional definition of advocacy. He then attempts to illustrate how this role involves engagement with the client(s). However this is a tentative appeal to nurse/patient collaboration in how this role is 'actioned' in practice presented in incomplete sentences and use of terms

such as *hopefully in collaboration with* which may suggest that perhaps it is not with the clients collaboration and then he makes a quick turn to, *but a lot of the time* (lines 3-4).

In so doing, he begins the process of justification and reflection in an attempt to repair a possible construction that might be construed, as he is not involving his clients in his application of advocacy role. This is done by making a case for the nature of the client group he works with and how their mental health problems preclude engagement at this level all of the time, because they are *unable* to function in ways that would make this relationship possible (lines 5-6). These non-normative dispositions justify the exclusion of some mental health clients in the advocacy process and also serve to account for their 'learned helplessness', which is then presented as *institutionalisation* (line 7). J ponders this for a moment, reflects and then confirms his diagnosis where he is *sure it is*, rubber-stamping this with *as a matter of fact*, (line 7) which defies argument. By making his diagnosis a 'fact', he distances himself from the allocation of institutionalised construction of the mental health clients that he has just presented and in so doing 'repairs' any potential opinion by the listener/reader regarding the use of this terminology. Woolgar (1988, p.75) calls these fact constructing devices externalising devices.

In the following extract, M signs up to 'the importance of advocacy' with J, but interestingly in her contribution to this discussion, she presents advocacy as important in a way that suggests this sits within a hierarchical relation with other roles, with some roles being more important than others. 

There then follows an unusual statement, whereby she ‘accepts’ this role, she takes it *on board* (line 10). She again thinks carefully about this and presents a notion that some nurses might not be aware that they are fulfilling an advocacy role, but follows quickly on this by excluding herself strongly from this scenario by stating *I certainly do* (line 10-11). She then moves to present examples of how she carries out her role as an advocate as a means of validation as seen in the small extract from this data. In the validation process use is made of extreme case formulations *certainly do* (line 11) *and all sorts of things* (lines 11-13).

11.it (..) I certainly do (..) making phone calls (..) appointments (..) all sorts of
 12.things on people’s behalf (..) you (..) we’re meant to know (..) we’re meant
 13.to know everybody’s (..)=
 [FG1]

The indexical nature of this discussion is seen in the next segment from the data where F takes up M’s conversation by picking up on the next section of talk, which centres on all of the things, as this group of nurses sees it, are what mental health nurses are expected to know. Thus adding to the ‘complex identity’ construction.

14.F = Yes (...) we’re meant to know everybody’s
 15.resources eh (..) allowances (..) yes (..) you’d be amazed at what we’re
 16.expected to know (..) so we’re very much patient advocates and again
 17.relaying it at consultant’s meetings and the doctor will say and what do the
 18.nurses think (..) what’s the nursing staff opinion on this so again you’re
 19.relaying a nursing opinion to the medical staff (..) I think the patient sees us
 [FG 1]

Once it is made clear in F’s extract of talk above what it is they are expected to know, the breadth of this knowledge is presented in such a way that myself (and others who read this work) will be *amazed* by this diversity (line 15). Again this makes a strong case for the ‘complex identity construction

construction’.

Another aspect of the construction of a complex ‘identity’ is presented by the participants in their accounts of involvement in client education.

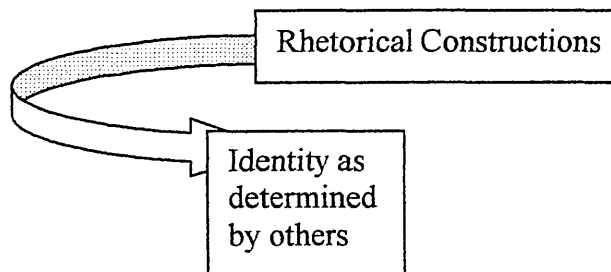
- 1.M =You’re there to
2. educate as well and obviously you do this in the long stay
3.as well (..) you know regarding obviously (..) diet as well (..)we get a lot of
4.people with eating problems and things that come in (..) drugs you know (..)
5.and what not (..) just to comply with medication (..) so then we’re educating
6.them =
7.J =Yea (..) but no
8.everyone’s amenable to other forms of intervention or (..) eh (..) education
9.until they’ve had a therapeutic dose of medication in them (..) well hopefully
10.when you’re (..)em (..) living part of your life with (..) especially with long
11.term (..) they’re in a longer period of time than they are in acute (..) and
12.they’re spending a great deal of their lives with you and you with them (..)
13.hopefully in that period of time you’re going to influence in a positive way their
14.mental state and their attitudes towards (..) towards life =
[FG1]

In this account, M, who works in acute psychiatry, subscribes to the notion that the mental health nurse’s role in patient education is common across the disciplines of mental health practice making the claim that *obviously* J would undertake this activity in long stay psychiatry (line 2). She cites diet, eating problems and drug problems and compliance with medication as examples of the types of patient education topics that are relevant for this role. In so doing, she validates her statement and justifies the role of patient education as being a mental health nurse activity. Albeit, J presents a cautionary caveat to the efficacy of patient education alone as a means of therapeutic change for his clients. He makes the claim that for some, medication serves as the primary therapeutic intervention augmented by a nursing environment of patience and influence, which over time may facilitate change naturally (line 7-8). This section of the analysis chapter has explored the nurses’ constructions

of 'complex identity'. With structures that include rhetorical accounts of individual practices, explanations and justifications for the extent and diversity of knowledge and skills and the constructions of the complex nature of the client groups that these nurses work with as linguistic devices to support this identity construction.

To build on this notion of complexity of identity, the following identity repertoire looks at the nurse participants' accounts of how others have constructed mental health nursing.

6.2.4 'Identity' as Constructed by Others



In the following extracts the participants present accounts that are of interest in relation to how the nurse participants' construct their 'identity' as being constructed by others who have particular positions regarding mental illness and mental health nursing. How this is introduced as an issues in the nurses talk is of interest, and includes media representations, views and opinions of others as expressed in the use of the discursive devise coined by Wooffitt (1993, p.158) as 'active voicing' as a discursive device to make a factual claim. The participants' also make use of

metaphors as a performative discursive device in the descriptions within their accounts.

In the following extract of data, Col uses the active voicing device in his account when he presents an example of what might be emblematic of a comment at a job interview (lines 6 –7). It serves two purposes in this stretch of text first to construct the notion that the skills and qualities required of mental health nurses have significantly moved on over the years, *do you play football?* (line 6) and that jobs in that era were easy to come by, *you can start on Monday* (line7). An account that reflects the discussions made in chapter 2 of this research in discussing history and gender issues in mental health nursing.

- 1.Col =But(..) I do make quite clear to people that we are not CPN's (..)
 - 2.but to get back to the question of what we do (..) I think that's always
 - 3..like eh (..) the quest for the Holy Grail (..) because we can't (..) I don't know
 - 4.it's like (..) eh (..) it used to be a job that people would go into when (..) it was
 - 5.there (..)I mean it was a joke at the hospital I used to work in (..) in
 - 6.Inverness that (..) [talking about the interview and selection process] "do you
 - 7.play football, well you can start on
 - 8.Monday" (..) but we don't want to go back with that'
- [FG2]

Col's frustration in determining what it is that mental health nurses do is reflected in his use of the metaphor inline 3 the *quest for the Holy Grail*, the etymology of which places determining what mental health nurses do in a near impossible but extremely important frame.

Researchers that have explored the use of metaphor in discourse include Lakoff (1991) in his Internet paper of the different metaphors used in the United States to justify their role in the Gulf War of 1990 and Coates et al. (1994) who explored the use of metaphor in analyses of descriptions of rape and sex attacks. The point is that it is sometimes difficult to define

the nature of events in an appropriate way because there are inadequacies in the descriptive repertoires available. This can be applied to the 'doing' of mental health nursing and supports the need for 'identity' research in this field.

In the following extract, which is a discussion on advocacy, Col continues to focus on mental health nursing within a historical frame. However, in this extract, he uses film media as a device to present a construction of mental health practice that acts as both an endorsement of past practices and provides an extreme contrast structure for present practice. He attempts to recruit the participants in this discussion to this version of reality by making a claim that they are all of an era where this type of practice could be accepted as an accurate construction of events (line 1). Institutional practices as cited by Goffman in *Asylums* (1969), which reinforced the depersonalisation of individuals and their 'transformation' from people into patients by taking away their personal clothing, and replacing this with institutionalised 'uniforms' or indeed night clothing, is discussed and presented. But Col, in his account, having recruited his fellow participants vicariously [because of their age and when they trained as nurses] to these activities earlier then moves back from his own personal engagement in this type of activity by suggesting that *it was a bit before his time* (line 4-5). He continues with the portrayal of the 'account within his account' (lines 5), and makes a strong judgement position on this fictitious action in line (line 5) *now that is awful*. His account then addresses more robustly, his version of the film *One Flew Over the Cuckoo's*

Nest and Col's opinion of the 'problematic patient' (lines9-11) portrayed by actor Jack Nicholson in this film.

- 1.Col =Advocacy (..) I think we are all probably from a time when a
 - 2.patient came into the system (..) events were really strictly controlled
 3. that (..) eh (..) it would be a bit before my time (..) but it would be (..) well
 4. we'll take away your clothing from you and if you can be trusted we'll give
 5. you back your shoes (..) now that is awful (..) eh (..) I think you know (..) if
 6. you do get a patient (..) in fact a good way to describe this is we've all
 7. seen the film 'One Flew Over the Cuckoos Nest' (..) which I think is a
 8. film that is liked by psychiatric nurses and I don't know why (..)
 9. because if you had a patient like the character played by Jack
 10. Nicholson (..) would you actually (..) would you want a patient like that (..)
 - 11.no (..) because they would be so problematic that (..) just really (..) to return to
- [FG2]

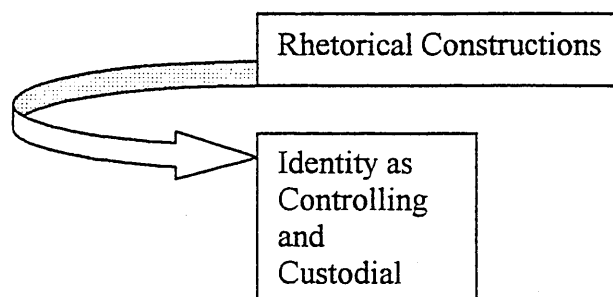
A little later in this discussion, Joss returns to the characters in the film and concerns himself with an analysis of the behaviour of the film character Nurse Rachett. His view being that the public perception of Nurse Rachett is not one that he would want to cultivate because of her lack of perceived relationship with the mentally ill clients. Examples of the Nurse Rachet practice that reflects this distance are presented by Joss in his account in lines 1-8. He dismisses this practice totally in line 8 *that doesn't happen* and Paul closes the book on this discussion by making a statement for the whole of mental health nurses in line that it is *wrong* (line 15).

- 1.Joss =Do you not think that the role of nurse Ratchett there [referring to
- 2a character in One Flew Over The Cucko's Nest] (..) you know (..) I
- 3.mean it's something that you wouldn't like to cultivate as (..) as
- 4.people's perception of psychiatric nurses (..) because I think very much
- 5.that's what they see (..) you know the distance between the psychiatric
- 6.nurse there and the patient (..) and you know (..) they were in a kind of
- 7.cubicle dishing out medicines and the patients kind of queued up for
- 8.their medicine(..) that doesn't happen (..) you know because nurse
- 9.Ratchett in the film didn't cultivate the relationship with the patients (..)
- 10.it was very consistent (..) you know and the relationship was in a group
- 11.setting=
- 12.Saul =I think she (..) she thought she was cultivating relationships with
- 13.them (..) but she wasn't really (..) as an outsider (..) we though=
- 14.Paul =Well (..) we
- 15.know as

Joss, in lines 3-5, challenges Nurse Rachet as a role model for mental health nurses, but also suggests that the public do perceive mental health nurses to be like her. An interesting point arises in lines 12-13 that, despite the film portrayal of this character they conduct the conversation as though this person existed, *she thought she was cultivating a relationship with them*, Saul wrestles with this one and comes to the conclusion that this was not the case. In the version presented by the participants and again if the analysis is to be robust, one must ask what is it that they are doing with this talk? And how are they doing it? It would appear that they are constructing themselves in the construction of this media construction. By that it is proposed that in identifying actions and behaviours presented in the film by Nurse Rachett they are making a case for this NOT being what mental health nursing is. Nurse Rachet gave medicine out from within a cupboard. This does not happen (line 7-8). Nurse Rachett didn't form a relationship with her patients. She was *an outsider* (line 13). We know that was all wrong (line 15).

There is a wealth of literature on media representations of mental illness, all of which portray an extreme case of those with mental health problems and a particular view of those who work with them. This will be further discussed in the following chapter. In continuing the process of data analysis, the following ~~the~~ construction of mental health nurse identity as custodial and controlling follows.

6.2.5 'Identity' as Custodial and Controlling



In the following extract of data an account of nurses work within a rehabilitation ward is presented. In discussing this account, the participants begin to question the practices that take place in this environment and they collectively make a case for mental health clients potentially being in care environments that are inappropriate to their needs. These environments are rhetorically constructed as *'holding areas'* by the nurse working in this area (line 4). The construction is one of a ward held because they have *nowhere better to go* (lines 4-5).

There is an interesting relationship between attributional explanation and the social construction of identity in this piece of data and it can be seen that these occur reflexively in the following data extract.

1. Saul =I think my job differs in the view that I am hospital based(..)
2. working primarily (..) as I say in the rehab (..) eh (..) ward where we're (..) I
3. mean (..) we're looking after the sort of enduring mental health problems (..)
4. em (..) I think historically it's been looked at as a kind of holding area for
5. people (..) em (..) as there's not been any facilities for people to move out into
6. a community base (..) considering (..) after being in hospital for such a long
7. length of time (..) and there's maintaining their social skills(..) enabling them to
8. be as much(..)selfsufficient as possible (..) to be able to cook and putting them
9. through cooking programmes (..) I think to all intents and purposes a lot of
10. them feel quite demeaned (..) in a way by that (..) for the fact that they've
11. maybe been out at some stage (..)and they can cook (..) and yet we put them
12. through programmes (..)to (..) you know (..)teach them how to cook (..) for all
13. intents

and purposes some of them can actually(..)are pretty good at it (..) and 14.sometimes I think the needs (...) whose needs
 15.are sometimes getting met (..) in our ward environment (..) em (..) you feel
 16.sometimes (..) that we're putting people through programmes towards other
 17.needs and they (..) to be seen to be doing it (..) and you know morale tends to
 18.get kind of low (..) and everybody (..) you know (..) you try to muster this
 19.up (..) tend to do things with people (..) em..=
 20.Lu = Sounds like they're justifying
 21.their shifts doesn't it?=
 22.Paul =Yeah that's another point(..) part of our role is that we
 23.assess
 24.peoples' capabilities (..) and without being too critical (..) do you not think
 25.that's just been an inaccurate assessment (..) then if you're saying that you're
 26.doing cooking skills with somebody when they can already cook (..) or they
 27.display some ability to cook=
 28.Saul =You tend to find that the good (..) the (..) the
 29.kind of better ones (..) you find get involved in these things and they continue
 30.to do it with these people because (..)=
 31.Sue As you quite rightly pointed out (..) that it might be the case (..) that these
 32.people are sitting on the ward because there's no place else for them to go=
 33.Saul =
 34.That's right (..) it's a holding place (..) it's maintenance=
 35.Sue =Yes (..) it's a holding place
 36.(..) so although as [names nurse] quite rightly pointed out (..) whether it's a
 37.poor assessment or whatever else (..) it's because these people have no where
 38.better to go
 [FG2]

In the following small extract taken from the above data, Saul identifies himself as a particular type of nurse, locating this identity in the context of hospital based care (line 1), as opposed to some of the others in this focus group, who work in community care settings. In so doing, he presents a number of key points. First, is the tentative construction that his job is different from others in this discussion group, positioning his work in an institutional environment. Thus contributing to nurse 'identity as being different' compared to other colleagues. Second, he uses medical jargon *rehab* (line 2) to link the nature of his work environment with the nature of the client group, *enduring mental health problems* (line 3), albeit he does not personalise these clients, referring to them again in medical terms. Thus he subscribes to the traditional medical model.

The use of medical labels or ‘diagnoses’ can be construed as reductionist and used to pigeonhole people, reducing them to ‘nothing more than their diagnosis’. In the context of this focus group discussion, they become rhetorical devices used by people to hang their individual prejudices, fears and political proclivities upon. Third, in lines 4 and 5 he overtly links the area in which he works within a historical context and justifies this with a past and current socio-political issues that being the lack of appropriate community service provision for this client population.

1.Saul =I think my job differs in the view that I am hospital based(..)
 2.working primarily (..) as I say in the rehab (..) eh (..) ward where we’re (..) I
 3.mean (..) we’re looking after the sort of enduring mental health problems (..)
 4.em (..) I think historically it’s been looked at as a kind of holding area for
 5.people (..) em (..) as there’s not been any facilities for people to move out into
 6.a community base (..) considering (..) after being in hospital for such a long
 7.length of time (..) and there’s maintaining their social skills(..) enabling them to
 8.be as much(..)selfsufficient as possible (..) to be able to cook and putting them
 [FG2]

This has the function of placing the remainder of this discussion in a context where the value of the work that the nurses are doing is questioned and the appropriateness of the care environment is challenged. A sensitive reflection of the impact on clients involved in therapeutic activities that are not appropriately matched to their level of needs is presented in line 9, *a lot of them feel quite demeaned*.

The notion that nurses carry out activities in order to be seen to be ‘doing something’ is worked up in the following short extract with a related construction of the potential impact on staff morale regarding carrying out these practices. Within this stretch of data a proposition that there might be conflict of interest regarding whose needs are being met in working this way is presented as a value statement.

Luke follows this up by making a judgement statement in lines 7-8 in relation to the preceding account, taking the position that the nurses are *justifying* their existence.

1. are pretty good at it (..) and sometimes I think the needs (...) whose needs
2. are sometimes getting met (..) in our ward environment (..) em (..) you feel
3. sometimes (..) that we're putting people through programmes towards other
4. needs .and they (..) to be seen to be doing it (..) and you know morale tends to
5. get kind of low (..) and everybody (..) you know (..) to try muster this
6. up(..) tend to do things with people (..) em..=
7. Luke = Sounds like they're justifying
8. their shifts doesn't it?=
[FG2]

It is interesting that Saul, who began this account, talks in the main in a personally detached way, using *we*, *you*, *they* in the account of practice rather than *I*, *me*, *my*. The concluding attribution in this discussion being that nursing practices and clients experiences in this context happen *because* there is no place else for the clients to move on to.

In the following piece of data, the construction of work in a long-stay, hospital environment is presented by J

1. J = Just before you spoke there (.) I was thinking about (.)you
2. know (.) e:h (..)it's quite (.) new and unique (.) e:h (.) to be working as a staff
3. nurse (.) and in the long term care setting (.) e:h where I am just now (.) e:h (.)
4. I'm ve:ry much aware that historically (.) the work that we do (..) that nurses (.)
5. e:h do in psychiatry is pretty much custodial (.) and I'm working alongside the
6. legacy of that to this day (...) It's awkward at times (.) and it's always
7. ques:tioning what my role is
[FG1]

There are three key elements in the above extract that are interesting. The first is the connection that J makes between the long-term care setting and the custodial role. The second is the connection made between the custodial role, the history of mental health nursing and its' historical legacy. The third is the notion that his client group's past and present care extends

over a lengthy period of time.

Using Pollner's (1987) concept of mundane reason, in the above extract, J presents his account in a way that appeals to the assumption that the others in this discussion have access to and subscribe to the same underlying 'reality', that is *that the work that mental health nurses do is pretty much custodial* (lines 4 and 5). It is a seductive proposition, premised on a notion that has been the centre of a web of beliefs about mental health nursing over time. It subscribes to a commonly held a reality about the mentally ill and those who work with them. In exploring how mundane reason is operationalised in this context, Pollner's (1987) principle has been followed in the analysis. That is, asking not how could we believe anything else, but rather to explore how this device contributes to a representation of identity in the face of accounts from the other participants of their practices which may counter this position or sit in parallel to it.

In the following extracts, all participants use language in a way that appears to be easily understood by each other. They appear to be familiar with legal and professional jargon associated with their practice and this is demonstrated in how the conversation flows easily between them. There are no requests to explain terminology or accounts of practices by the participants. Therefore, in some way a commonality of understanding is demonstrated throughout the nurses' discussions at a rhetorical level. However, like 'the mirror and the construction yard' metaphor presented by Potter (1996, p.97), in relation to fact construction in this research at this point.

The identity construction of mental health nursing as custodial rests not in any individual cognitive concept of what constitutes 'custodial' but in the rhetorical descriptions and accounts of custodial practices presented by the participants, and the ways in which they work up these accounts to present versions and explanations of what they constitute as custodial in a given context. Thus the argument is that the participants' talk is part of social processes rather than mental versions of the world.

Krippendorff (1980, p.133) argues that all researchers are "discursively constructing the very contexts that render their data meaningful". Thus, in presenting extracts of data in the text of this work, for the reader to see is premised on the notion that the reader has as much information as the researcher in relation to how the analyses have been undertaken and developed in this work.

As is the case throughout this work, the participants mobilise a range of discursive constructions and rhetorical devices in their talk. In the above extract the custodial aspect of J's practice is occasioned within a historical context, albeit his choice of phrase, *working alongside it* (line 5) is interesting. He could easily have firmly embedded his practice *within* this historical context, but he has rhetorically distanced himself from this and in so doing helps to make his plea that it is *awkward* (line 6) more convincing. He is *very* much aware of the historical implication of the nurses' work (line 3). Albeit, he does not expand on what these implications are. The use of the extreme case formulation *very much* emphasising the strength of his statement. The custodial identity is presented

as problematic by J in line 7 where he is *always questioning what his role is*. The literary definition of custodian is that of keeper or guardian with contextual connections made to imprisonment, and arrest. These are not the most appealing role associations for nursing, which has ‘softer’ connotations that include caring, tending and looking after. It is also interesting to explore how the term custodial is presented in a given context. In this research, the main focus of this is in relation to mental health legislation, detaining clients in areas against their will or because they have no-where else to go. Thus the participants in presenting ‘custodial’ in this way, are developing a contrast structure that assumes that anything not in this context is therefore not custodial and by implication not controlling. In this data piece, J adopts a slightly diluted and distanced position in terms of his involvement in a custodial role in his use of *pretty much* custodial (line 5). Thus J’s construction places identity in this context, at an individual level by providing cultural narratives, representations and ideologies around what mental illness and mental health nursing is. Wetherell and Maybin (1996, p.27) describe this as cultural narratives that become a set of personalised voices and positions. Within this context, for this research, J’s notion appears to be situating mental health nursing activities that sit at the interface of caring and custody.

The issue taken up by M in the following extract of data, while providing an account of an aspect of her own work with her particular client group, who are clients in an acute care setting.

1. M. =yeah (..) sometimes we are custodians. You may ha:ve to detain
 2.somebody
 under the

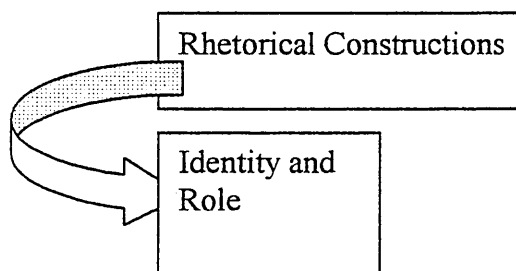
nurse's holding power (...) or detain somebody under
 3. Mental Health Act. Your job is then to observe them to make sure they're still
 4. on the ward (...) to keep them on the ward (...) if they're attempting to leave
 5. and then (...) so (...) you're looking at the priority being the patient's safety (...) that's
 6. your priority (...) to keep them safe. So (...) in that way you're taking over
 7. part of their (...) personal responsibility (...) to an extent you may be
 8. infringing on their rights (...) but you're weighing it up (...) you're weighing it
 9. up every 24 hours if somebody's going onto obs (...) you're looking at it every
 10. 24 hours so we still because it's an infringement of their rights (...) but you're
 11. always weighing up the patient's safety. I think it's an important part of the
 12. role because (...) it is an infringement of their rights.
 [FG1]

In the above stretch of data, M concedes that mental health nurses *sometimes*, have to adopt custodial practices (line 1) and undertake activities that infringe on individual rights (line 2-3). In her presentation of this account, she brings into the discussion references to powerful legal discourses which legitimate her ability to hold a person in hospital against their will, '*The Nurse's Holding Power*' (line 2). This privileges mental health nurses with a particular power status over the patients in their care. Alongside this M refers to the Mental Health Act, within which the Nurses Holding Power is situated. It is used in this section of data, by M to compound the legal justification for the constraint of clients. It is interesting, however, in the above extract, that M does not 'sign-up' to using the nurse's holding power herself. Rather she uses the pronoun 'you' in this context which can be interpreted as 'nurses in general'. Once M has presented the case for 'potentially' detaining patients, *you may be infringing* rights (line 7-8), she then provides a persuasive justification for detention practices, by appealing to moral and social issues. These devices are mobilised and occasioned in a 'client safety' perspective. Patient safety is formulated as a key priority that is stated not once, but

three times in this short piece of talk (lines 9-12).

Another interesting inclusion in this extract is the issue of continual appraisal of the *status quo*. The patient is continually assessed and monitored in relation to the detention against his/her will. They are observed *every 24 hours* (lines 10-12) with the use of the exact hours, presented twice, serving to emphasis that this activity is ongoing and is not simply something that happens at some time during the course of a day but rather is an ongoing activity which continues all day, as a means of ensuring that clients are not detained under these legal conditions for longer that they need to be.

6.2.6 'Identity' and Role



In the following segment of data, M and F collaborate in the development of their construction of an administration/managerial role repertoire.

1.M = the role is never ending (..) again in the acute ward (..)we're constantly
2..looking at paper work (..) with admissions and discharges and care planning
3.(..) eh (..) the computer (..) em (..) quite a turnover of patients and then the piles
4.of paperwork reflects that (..) the phone never stops ringing=
5.F =here (..) I've just
6.come out a ward meeting which I went in at half-past nine and came out the
7.meeting at half-past twelve (..) and that's me just finished writing up the
8.notes from it (..) at this meeting I'm talking on behalf of all the patients (..
9.you know (..) talking for the key worker (..) you know the key worker writes
10.what they want to be said for their own client (..) just passing that on and
11.discussing through this with the ward doctor and consultant (..) and we
12.always (..) you know (..) keep the (..)you know the key worker sits down with
13.the client and if you want to discuss (..) em (..) medication (..) if they've got
14.any
complaints

about it (..) you talk about passes (..) things like that (..) or if a 15.family wishes maybe
to speak to a doctor or that (..) you always ask the client
16.first (..)and you tell them that will be put down to the consultant (..) on certain
17.occasions consultants do make changes and leave it up to us to pass onto them
18(..) like (..) which annoys us a times=
[FG1]

M's opening line contributes to the complex context repertoire that took place at the beginning of this discussion the *role is never ending*. There then follows an account of the administrative/managerial repertoire which included dealing with lots of paper work in relation to the relatively quick turn around of patients in acute psychiatry, in this context in comparison to J's rehabilitation/long stay client area. The introduction of information technology in health care is referred to in line 3 where computerised care planning is the 'norm' in this area. Compounding the administration drudgery is the need to attend to telephone calls (lines 1-4) and the extreme presentation that the phone *never* stops ringing. F takes up the construction in lines 5 to 9 when she describes in precise terms the three hour long meeting and note writing experience she has just undergone with the ward medical staff. She includes in this section of text the interesting hierarchical 'pecking order' presentation of the 'ward doctor' and 'consultant', the role of the key worker as the nurse who works for and with the patient and their families and her own role in presenting information at this meeting. The power relationship of the consultant is strongly portrayed in this extract, despite reference to advocacy repertoires, and collaborative practices. In lines 16 and 17, it remains the consultant's decision, which is paramount, and *on certain occasions* the consultants make changes in light of the discussions that take place at these

meetings. However, the outcomes of these decisions are apparently left to the nurses to convey to the clients and their families, much to the chagrin of the nurse. The following stretch of text makes use of adult [general] nurses as significant others to develop a contrast structure between them and mental health nurses (lines 1 –2). The notion that adult [general] nurses are more focused on the physical health problems of individuals is presented by M in a way that makes it appear that what they do is less important to that of mental health nurses (lines 2-3) and she repairs any suggestion that her description might offend by suggesting that she is perhaps being ‘unkind’ in her generalisation of their role. This is given additional weighting by justifying why it may be the case that the physical health problems take priority over the individual with the health problem (lines 4 and 5), people are presented as being processed quickly through the system and the time it takes to build relationships is compromised as a result of this. This again presents a comparison structure between two client groups, those who need to receive physical care are presented in a functional ‘conveyor belt’ image, emphasised by the use of a three part list device which highlights the ‘processing’ of the patient experience in general nursing, ‘they go in, it happens to them, they go away’ (lines 8-9).

1.M. = all the dimensions we have(..) I think general nursing (..) maybe I’m
2.being a bit unkind to them (..) but I see them being primarily concerned with
3.the person’s physical state (..) em (..) the relationship with the patient is
4.secondary to that (..) people come and go very fast in general hospitals these
5.day’s even with major surgery they don’t have the time (..) or need at the end
6.of the day to build up the same kind of relationship with the person as we
7.do (..) em (..) people have expectations when they go into a general hospital
8.what’s going to happen to them (..) they go in (..) it happens to them (..) they
9.go away again (..) it’s not like that here (..) our (..) our (..) our role is (..) we
10.look at people in a very holistic way (..) we have to look at them in a far more
11.holistic way because of the problems they have are not going to be as straight
12.forward =
13.J = I think maybe nursing
14.specialities
s like general

nursing they may medicalise things (...) whereas we

15. can't

16. M I think we make a definite effort not to (...) not to medicalise=
[FG1]

In the above extract, the distinction between mental health practice and that of their adult [general] counterparts is reinforced by M who claims in line 16, using an extreme case formulation, to make a 'definite' effort not to medicalise her clients. Lines 10 and 11 in this stretch of text are also telling in that there is a construction made of individuals with mental health problems being complex, and as such being able to apply a 'whole' person approach to working with them is the more appropriate approach. The notion of the interpersonal nature of mental health nursing is illustrated in the construction within the following extract of data. Here Prue describes what she does as a 'talking job' (lines 3 and 4). However, it is presented in the context of facilitating peers rather than working with clients in this extract. Thus adding staff development to the complexity of the mental health nurse identity construction.

1. Prue =I think my job is to facilitate things it's to (...) it's (...) I'm there
2. a support for people in terms of what they do in their practice (...) and
3. problems or difficulties they have (...) and I (...) you know (...) it's a talking
4. job (...) that's what I do (...) and it's mainly staff I talk to (...) just to facilitate
5. em with any ideas they have (...) I'll help them see it through (...) that's my
6. le (...) it's also a lot of the other management stuff that you get landed
7. with (...) all the stuff that nobody wants like disciplines (...) and sickness (...) and
8. sence (...) and stuff like that (...) there's lots of tha=
[FG2]

This representation of the complex nature of the mental health nurse is to be found in the participants' construction of the 'administration and managerial repertoire' of role. Administration in nursing practice has been alluded to earlier in this chapter by J, who, he claims immersed

himself into this aspect of his role as soon as he became a staff nurse in the rehabilitation ward in which he works.

In lines 3 and 4 Prue elaborates the dynamic nature of her 'talking job', which embrace facilitation, supporting, talking to, problem solving. The less appealing aspects of her managerial role are presented as stuff that you get landed with (line 6 and 7) and nobody likes.

This short extract serves to contribute to the complexity and diversity of the role of the mental health nurse.

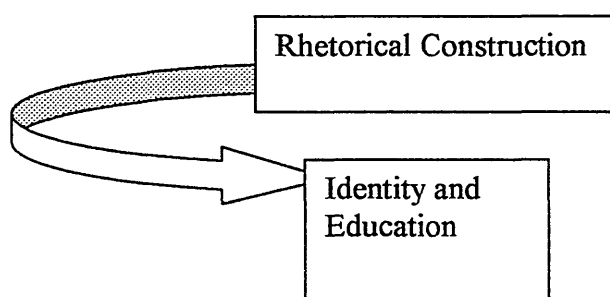
In the following stretch of text, the interesting construction of the mental health nurses as a friend is presented. This is an unusual concept, which embraces providing companionship, information giving and knowledge. In the following extract of data, Prue illustrates the operationalisation of this role in the context of a construction of clients who lack confidence or have what she calls deficits.

1.Prue =You're providing (..) maybe the likes of company (..) often than not(..)
2.but you're maybe (..) like the provider of friendship to someone (..) provider of
3.communication (..) the provider of information and knowledge that this person
4.maybe doesn't have (..) or doesn't have the confidence to go and find it, so
5.you're the provider of (..) you know (..) maybe certain deficits that this person has =
[FG2]

Identifying an aspect of professional practice that encompasses being a 'friend' is unusual in nursing. It sits close to the professional dividing line between practitioner and lay person and it is not something that is encouraged in its literal context within nurse education. Albeit, the notion of working with another individual in a spirit of mutual regard is something

that would be seen to be positive practice in mental health nursing. The concept of being a resource person for individuals is another aspect of the mental health nurses' practice, and endorses some of the claims made within this data that practitioners in this field of nursing need to comprehensive knowledge and skills base that goes beyond bio-medical knowing.

6.2.7 'Identity' and Education



In contrast to the general stance that mental health nursing is different to that of adult [general] nursing and claims made for interpersonal skills and holistic practice, in the following extract of data, there is recognition of the need for medical knowledge of the psychiatric condition and places this aspect of knowledge development clearly within the domain of 'formal learning' achieved in a college environment. However, as the discussion moves forward, F, moves on to evaluate the contribution of this medical epistemology in practice, viewing it as problematic.

- 1.F = You obviously have to have a knowledge of psychiatric conditions (..)
- 2.the ones you come across (..) and that's the one's you get at college (..)you
- 3.know (..) the main one's that you come across (..) but actually once you get
- 4.into the job you find that there's a bit of a problem doing that (..) You need to
- 5.now the importance of the therapeutic relationship (..) and how to establish
- 6.that (..) You need to know that you're the sort of person who can do that=

7.M =You need to
8.have clear communication skills (..) you couldn't come in if you couldn't
9.communicate=
10.F. =You could (..) but you just wouldn't get anywhere=
11..M. =No you
12.still could do it (..) but you couldn't get anywhere (..) It's about being able to
13.draw things out of clients you know (..) but just (..) you know (..) I think
14.being able to adapt really (..) you're adapting constantly (..) to whatever client
15.you've got at that time (..) as I say (..) from the over demanding work that
16.you've actually got to say "back off a wee bit" (..) you know (..) and as I say
17.drawing out of the really withdrawn client (..) getting them (..) again we can
18.jump from a really quiet environment one minute and within 2 minutes we've
19.got patients restrained on the floor (..) you know (..) fights going on (..) em (..)
20.it's just (..) I don't know how you would say it (..)=
[FG 1]

In the above extract, the participants' work at recognising the value of knowing about commonly recognised mental disorders. They *have to have* this knowledge (line 1), but go on then to expose the limits in practice of neatly packaging individuals in to medical labelling categories in favour of more humanistic caring approach.

The emphasis within the above data is then placed upon the *importance* of the therapeutic relationship (line 5) with this presented as a process that does not simply happen, but rather needs to be worked at in order to be effective. Also subsumed within this extract is the notion that a mental health nurse is a particular *sort* of individual. If we can read *sort* as having a particular identity, then this *sort* needs to have *clear* communication skills (line 6-9) and whilst they may be able to enter the profession without this particular level of communication skills, they are not going to succeed as a mental health nurse (line 9). The ability of the nurses, with appropriate communication skills, to encourage and seek information from their clients is also claimed to be a necessary quality in assisting nursing care. This is presented as a particular achievement when engaged in working with *really withdrawn* clients, highlighting as has been done in

previous discussions that there is a continuum of non-communication that clients demonstrate.

Also included within this extract, is the case made by M for the work and the working environment being dynamic and challenging making use of extreme formulations and precise time frames to make her point. In so doing, she contributes to the need for mental health nurses to have at their disposal a repertoire of knowledge and skills that can be drawn upon extremely quickly as the environment and client needs change.

As an adjunct to medical epistemology and humanism, M makes the claim that they are required to be knowledgeable about socio-economic issues, such as clients' personal finances and the various allowances they may be entitled to. The participants have also made a case for communication and the nurse patient therapeutic relationship as being central to their practice. The following extract is an interesting construction. It makes a claim for mental health nurses being required to be knowledgeable in these wider socio-economic issues (line 1). F appeals to our *amazement* at the need for mental health nurses to know these things. At the same time, she makes an interesting connection with this 'type' of knowledge and client advocacy (line3), which takes this activity into the realms of the practical affairs of client empowerment. And, finally, it constructs a position where nurses' knowledge is acknowledged by doctors (line4 –5). In presenting this talk, within talk, they create a vignette within the construction where nurses are valued for their degree and level of complex knowledge.

- 1.F Yes (..) we're meant to know everybody's resources (..) eh (..)
 - 2.allowances (..)yes (..) you'd be amazed at what we're expected to know (..) So
 - 3.we're very much patient advocates (..) and again relaying it at consultant's
 - 4.meetings (..) and the doctor will say " and what do the nurses think? "(..)
 - 5."what's the nursing staff's opinion on this?" (..) so again you're relaying a
 - 6.nursing opinion to the medical staff.
- [FG1]

In the above discussions, it is clear that aspects of identity of mental health nurses are grounded in a repertoire of knowledge and skills discrete to their practice needs, which in their own right are discursive constructions. Knowledge is also used as a rhetorical construction that serves to position nurses as having a certain status.

The value placed on the participants' formal education is given in the following extracts.

- 1.F I think most of what you need to know is not something you can be
 - 2.taught in college=
 - 3.M =You can't (..) you can't (..) no (..)=
 - 4..J =You were probably nurses before
 - 5.you came in to nursing=
 - 6.F = Probably=
 - 7.J =And the nursing college just developed it=
 - 8.M =I
 - 9.I think for us age helps (..) and I would agree with that (..) I think the colleges
 - 10.are seeing that themselves aren't they=
 - 11..F. =Yeah (..)=
 - 12.M =You're having to(..) I wouldn't have
 - 13.done this at 17=
 - 14.J =No=
 - 15.M =I wouldn't have done it at 17(..) I think the fact that we've
 - 16.all got past lives (..) we've been there and done it (..) certain things (..) you
 - 17.know (..)we can empathise with them (..) and you know it's easy to say you
 - 18.empathise with them but can you really? (..) because it's=
- [FG1]

There are two key discursive points in the above data. The first being that formal college education falls short in terms of appropriately preparing students for their work in practice and the second that the normal entry age of seventeen is generally felt in this group to be too young for mental health nursing. In the above data, J makes the claim that *you were*

probably a nurse before you came into nursing (lines 4-5) and recruits participants in collectively agreeing this position. This is compounded by the following account presented by M, who subscribes to the notion that colleges don't adequately prepare students to become mental health nurses. However, she takes this further by making the claim that this is not just a problem at the student level, it is a problem for nurses at the point of registration and beyond. She justifies this position graphically by providing an example of active voicing, as used by Wooffitt (1991, p.158) to establish the factuality of claims, in this case an example from practice of an extraordinary event.

1.M I think it's not something college prepares you for (..) there's lots of
2. things that college doesn't prepare you for (..) and you step onto the ward not
3. just as a newly qualified nurse (..) I would say once you get further on in your
4. training (..) and you start getting clients of your own (..) and they just drop this
5. bombshell on you (...) you know "I was raped by such and somebody" (..) and
6. you go (..) [raises eyebrows and takes a breath] and you sit there and think (..) well
7. it all depends on what I say now (..) and you think " bloody college never
8. said anything about this" (..) you know (..) and you sit there and you think (..) oh
9. God" (..) you know (..) because it all fathoms on what you say (..) I mean
10. (..) eh (..) you can lose a client in the space of seconds=
[FG1]

The reference to the client problem as a *bombshell* (line 5) serves to illustrate the extremely challenging nature of this problem and constructs this as being problematic in terms of how well individual nurses might be prepared to cope with this. Again reference is made to the failure of the college to prepare nurse to deal with issues such as these. There is a compelling projection of the anxiety of the nurse in this account and in potential implications for the patient if the interaction goes wrong (lines 7-10).

probably a nurse before you came into nursing (lines 4-5) and recruits participants in collectively agreeing this position. This is compounded by the following account presented by M, who subscribes to the notion that colleges don't adequately prepare students to become mental health nurses. However, she takes this further by making the claim that this is not just a problem at the student level, it is a problem for nurses at the point of registration and beyond. She justifies this position graphically by providing an example of active voicing, as used by Wooffitt (1991, p.158) to establish the factuality of claims, in this case an example from practice of an extraordinary event.

1.M I think it's not something college prepares you for (..) there's lots of
2. things that college doesn't prepare you for (..) and you step onto the ward not
3. just as a newly qualified nurse (..) I would say once you get further on in your
4. training (..) and you start getting clients of your own (..) and they just drop this
5. bombshell on you (...)you know "I was raped by such and somebody" (..) and
6. you go (..) [raises eyebrows and takes a breath] and you sit there and think (..)
7. well it all depends on what I say now (..) and you think " bloody college never
8. said anything about this" (..) you know (..) and you sit there and you think (..)
9. "oh .God" (..) you know (..) because it all fathoms on what you say (..) I mean
10. (..) eh (..) you can lose a client in the space of seconds=
[FG1]

The reference to the client problem as a *bombshell* (line 5) serves to illustrate the extremely challenging nature of this problem and constructs this as being problematic in terms of how well individual nurses might be prepared to cope with this. Again reference is made to the failure of the college to prepare nurse to deal with issues such as these. There is a compelling projection of the anxiety of the nurse in this account and in potential implications for the patient if the interaction goes wrong (lines 7-10).

In the following stretch of data, the concept of learning vicariously by using clinical practitioners as role models is presented. It does, though have a double-edged sword. On the one hand it is presented by F, as one of the *best* sources of learning (line1) but M in line 10 adds a cautionary note that it can *work the other way* highlighting that students often learn how not to do things in clinical practice by observing the practices of others.

1. F =One of the best sources of knowledge and skills
2. for students on the ward are role models on the ward (..) In the first few
3. days on the ward (..) you choose someone to work as your preceptor (..) and
4. who would be a good role model (..) and you pick up from these individuals
5. through experience (..) and through doing the same sort of thing=
6. J. =and
7. they're the opinions that you formulate very quickly when you're in a ward
8. (..)even within may:be the first couple of days (..) you know who you're going
9. to look to for advice and guidance and support=
10. M =It works the other way as well (..) you
11. know exactly who you do not want as a role model (..) they're the one's (..)
12. you know (..) "I will definitely not do what she has done"=
[FG1]

The use of the three part list in line illustrating what J perceives as the quality requirements of clinical role models, these being: *advice and guidance and support* (line 9). This stretch of data is interesting in that it presents a construction of the process of selection and recruitment of appropriate role models, and exercising highly selective judgement skills in determining the difference between good and bad practice as demonstrated by these practitioners. It also presents an account of learning through experience, *you pick up* (line 4-5). Learning takes place experientially in this context.

In the following extracts of data, the nurses in this group talk about education and 'becoming' nurses. In opening this discussion, L (line 1)

subscribes to the notion of continual professional development and life long learning and S (line 4) affirms this by presenting an analogy of initial nurse education being likened to an apprenticeship, gained through the process of ongoing and continued exposure to a range of different experiences and activities that collectively contribute to 'becoming' a nurse.

Q: What specific knowledge and skills are required to fulfil your role(s)?

1.L:Everything there is to be known: in that: say: it's a chosen area: em:
2.continual development, continuous study ? =
3.S: = I think you need to
4.be a good communicator. It's like the old system years ago when people
5.went into, a: maybe: a:n engineering sector and they got their
6.apprenticeship and went through all the different departments and they
7.picked all the wee bits of information and they specialised =
[FG2]

In the above extract L, in the first line, uses extreme case formulation to respond to the interviewer's question. Despite the practical unachievable notion of this answer, she presents this as a case for the complexity and diversity of mental health nursing as described by her colleagues in this focus group discussion. Thus, presenting an example of the indexical nature of interaction in this discussion group. L's use of the term development (line 1) is interesting. Later in this discussion, she signs up to the notion that learning through experience is a valuable resource, particularly when dealing with difficult and challenging issues.

The concept of a wide ranging, skills based educational premise is taken up further in this discussion, when S develops a case for a comprehensive range of abilities that he claims are necessary for him to work effectively with others. He also, in this extract makes it evident that mental health nurses need to be able to assess not only their clients' mental health but

also their own abilities to work with these clients and, where appropriate, those of other professionals in the health care system. In so doing he recognises the importance of networking as a resource.

1. S = I think you need: personally: for myself I need to feel that I've got a
2. competent level of knowledge about what I should go out looking for(..)
3. and the actual skills I should be practicing with that person: that I should
4. have good assessment skills: because if you go out and you can't assess
5. somebody's deficits and capabilities: then it's a waste of time(..) so I feel
6. you have to have a really good: sound knowledge: a local knowledge as
7. well: you need to have awareness of local services: and not just utilising
8. your own skills but bringing in other people as well(..) and knowing how
9. to do that: networking with other people eh (..) promoting your own
10. service: going out and saying to people 'this is the job that I do': part of
11. the reason is to network with other people (..) and find out about their
12. service and tell them about mine: so you know: to me that's a skill: if I
13. can go out and do that
14. [FG2]

Following on from S's, position, P, makes a case for the mental health nurse as an educator, and in so doing makes a clear argument for the development of learning from novice (student) to expert (a practitioner).

1. carers e::m (..) just general communication skills. and I think we do build
 2. these up as you practice. From being a student to being a practitioner.
- [FG 2]

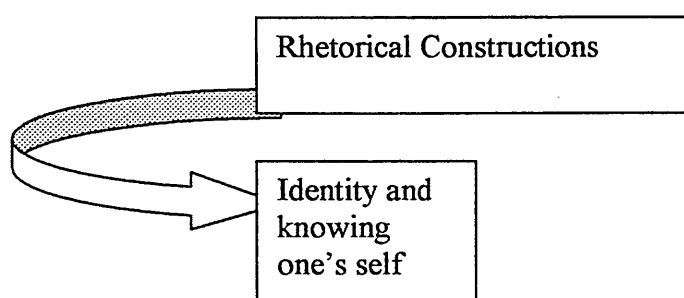
Within the following piece of data is a tentative construction of nursing autonomy in decision making and diagnoses (line 1-9), where she is presenting a case for making judgements based on her assessment of symptoms presented by her client(s). She aligns this autonomy with the absence of a doctor in this clinical area and the lack of need for one to be present. This is reflected by L in this extract of data in line 4 *recognising symptoms* and again in line 6 *recognising that this person is seriously suicidal*.

1.L = I think. In [names
 2.practice area] one of the things is again looking back to the fact that there's
 3.not a doctor there. you know. we don't al:ways necessarily al:ways need
 4.one. and it's recognising symptoms. and that was one thing I had a problem
 5.with when I came in. because it may: be (...) becau:se. if you don't
 6.recognise that this person is seriously suicidal and you close the doors at
 7.five o'clock and go away home (...) Yes. e:m. and it was the one thing that I
 8.found that the other nurses that I worked with had gained through
 9.experience =
 [FG2]

L's use of extreme case formulations in her talk is worthy of further consideration at this point. The construction of individuals with mental health problems has been the focus of researchers for some considerable time and has been referred to at frequent points within this research. In the short extract above, L uses extreme case formulations to powerfully portray a picture of the mental health client in question as being in a critical state, not simply suicidal, but *seriously suicidal* (line 6). This presents the notion that there are levels of clinical decision making that are undertaken when determining the client's condition. This places the nurse in an extremely powerful position professionally, morally and ethically in situations such as the one described, which may contribute to distinguishing mental health nursing as a different type of practice from other nursing disciplines. It suggests that there exists a continuum of suicide risk and that nursing decision making in situations like this involves determining where along this continuum a person's risk to himself lies. The implications being worked up in this construction are that within this practice area, ~~this is a situation~~ nurses have to deal with situations like this and their role includes the ability to assess risk and make decisions based on their assessment skills. In L's case, she alludes to the notion that if she left work at the end of her day the consequences

for the client might be serious. The use of the precise time, *five o'clock* (line 7), clearly registering to the listener the 'normal' end of the working day for most people. This is coupled by the precise action that might be undertaken at that time *close the doors* (line 7) indicating a finality to the process which when undertaken bars the client from the nurse at this juncture. This sentence is left incomplete, which allows the listener (reader) to make their own interpretation of the implications for the client of the actions described.

6.2.8 Identity and 'Knowing one's self'



In discourse analysis, the concept of an understanding of our selves and others is viewed as a constructive outcome of discursive interaction. It is a concept that has received much consideration by theorists such as Billig (1991), Potter and Wetherell (1987), Widdicombe (1993) and Widdicombe and Wooffit (1995). All of this supports the notion that analysis of everyday discourse can result in fruitful outcomes if "there is close attention of the sorts of accounts which people offer in response to a variety of topics" (McKinley and Dunnett 1998, p.36). In this research

the importance on 'self knowing' in mental health practice is acknowledged by S in line 2 in the following extract of data. She enters into a 'self-dialogue' in lines 3-5 that illustrates the searching questioning that is necessary for such a process to take place. There is also a case made for genuineness in this process where S argues for honesty in line 4. However, she follows this quickly with an acknowledgement of human frailty in this respect.

1. S =I think
 2. psychiatric nurses. as well as looking at other people. have got to be able to
 3. look at them:selves as nurses. like 'what's my strengths, what's my
 4. weaknesses' :like. you know. be:ing honest. and we're not very good at
 5. that and: 'I'll do that and I'll take that on': and maybe not making a very
 6. good job of it. and maybe someone else could fill that role better =
 [FG2]

In the above extract of data, S is cautious in her appeal for self-awareness. She contextualises this, not in terms of 'individual' self-knowing, but rather within the contextual category of *looking at themselves as nurses* (line1). Thus the self-knowing that is constructed in this section has a relationship to the notion of nurse identity. The development of the argument for self-knowing is accomplished by emphasising the importance of reflective practice in *assessing their strengths and weaknesses* and of *self-honesty* (lines 4 - 6) highlighting the 'personally' focused nature of these activities and qualities and in so doing emphasise their contribution to the development of quality patient care. The participant also alert us to the fact that sometimes nurses 'don't get it right first time', hence the need for reflective practice (lines 5 - 6). The concept of accomplishment in relation to social constructionist, discourse analysis is taken up by Michael (1999). With the position taken that

accomplishment is an analyst issue. By that it is meant that the 'successful portrayal of certain identities' is mediated by the researcher in the analytic process. It is proposed that it has been achieved in this research.

The concept of being a 'knowing' practitioner is taken a step further in the participants' discussions as the talk moves from discussions about self-knowing, to reflection of their own practice and recognising the limits of their ability to work with a client or client group.'

- 1.J = (...)sometimes we do need to say (...) no I've done as much as I can here:
2. and I need to bring in another member of the team=
[FG2]

In the next extract of data, the participants then move to bring in a need to be aware of the boundaries of their role and that of other health professionals. They are then brought back to looking at themselves as individual practitioners by P, who argues for an existential way of working as a mental health nurse. The key feature to this analysis is that the individual participants in this research "demonstrate an interest in constructing a sense of who they are in a number of different conversational contexts, [in this case in the focus group discussion]. These constructive efforts are seamlessly woven into other concerns as a conversation unfolds" as McKinlay and Dunnett (1998, p.50).

- 1.Shere's us sitting here discussing what our roles are today: and what
2. we need to fulfil them: but what about the other professionals(..) GP's (..) if
3. we don't know what they are=
4.L =oh: yes: I know what you're saying (..) but they
5. have the responsibility: we don't=
6.S =but they ultimately do: I'm not taking that
7. away: but that's something they need to be aware of(..) we need to be aware
8. of our own roles=
9. P = could I just say I think our roles and skills are quite a

10. personal thing to us (..) there doesn't seem to be the same uniformity to the
 11. skills that we learn and practice (..) you know(..) you mentioned anger
 12. management (..) but) you maybe do it a different way than what I do it
 13. because: if you're dealing with a fracture: or whatever (..) there is a more
 14. uniformed way of dealing with that(..) I think that's where psychiatric nursing is a
 15. wee bit different(..) is that you know(..) the skills that we learn
 16. (..)quite a personal thing to us (..) and you try and develop those skills to suit
 17. your abilities rather than (..) there's various (..) vicarious ways (..) you learn
 18. from other people
 [FG2]

In the above extract, P (line 9 – 12) highlights a position that espouses learning through experience and from experience and in lines 17 and 18 he highlights learning from others, describing it as vicarious learning. He makes a case for developing skills and practices that are adaptable in their execution, depending on the individual nurse. In this extract the use of adult [general] nursing practices (line 13) such as dealing with fractures is made as a contrast structure to add weight to the claim that mental health nursing practice is more flexible in its delivery of client care.

1. so I mean (..) part of it's learning from other people's experiences(..) and part
 2. of it is research based (..) and also from other disciplines as well(..) getting
 3. prompts from them (..) you know(..) and if you're doing a joint session with
 4. somebody (..) say:ing 'perhaps you should have dealt with it this way'(..) or(..)
 5. 'I would perhaps have done it differently' (..)and that gives you guidance for
 6. the future
 [FG2]

In concluding this focus group discussion J acknowledges role model learning and the value of research based practice, but she also makes the claim that learning about one's self in practice can also occur through sharing practice activities in peer review sessions, similar in fashion to that undertaken in clinical supervision.

6.3 Conclusion

In this chapter an extensive, in-depth analysis of data has taken place. In this analytic process the emergence of participants' identity constructions have been presented and the analytic process that justifies them as such has been made. It is important to note that in presenting the data as it has been in this research the reliability and validity of the process of analysis is openly presented to the reader. Analyses of the sort demonstrated in this research affirm that identity is a complex phenomenon and that these analyses lead to a deeper understanding of the role of identity talk in mental health nurse research.

In the following chapter, discussions that are relevant to the outcomes of the analytic process are presented and are linked back to the aims stated in Chapter one.

Chapter 7: Discussions

7.1 Introduction

7.2 Personal Perspective: Reflections on a Discourse Analytic Approach

7.3 Professional Perspective: Identity Constructions

7.4 Research Perspective: Discourse Analysis and Identity Research

7.5 Policy Considerations

7.6 Conclusion

7.1 **Introduction**

This thesis uses a social constructionist, discourse analytic approach to explore discussions that took place in focus groups by registered first level nurses about their professional identity. Specifically, the rhetorical constructions of identity as presented by these nurses were analysed by examining ways in which they were expressed in their ‘talk’ in focus group discussions. At this point in research studies, it is generally the case the main empirical ‘findings’ of the study will be presented. In this thesis however, following the discourse analytic position, the discussions in this chapter are presented—as the researcher’s discourse on the discourses of the participants in this research. It is also proposed that this discourse on mental health nurse identities discourse has implications at a theoretical, professional and education level. As the discussions unfold, potential practical issues related to the analysis of data are proposed. In particular it is stressed how they may be used to inform and shape mental health nurse curricula. The ways in which this research may be used to inform educational policy with respect to the development of educational programmes aimed at mental health practitioners are also examined. Thus this identity research has the potential to further mental health nurse identity in response to changing health care practices, education and policies.

This chapter begins by revisiting the conceptual framework from chapter one, Figure 1 and takes cognisance of the aims of the research as presented in Table 1. In so doing, this chapter metaphorically ‘squares the circle’ of this research, thus illustrating that the structural goal

requirements of beginning, middle and end of this research have been achieved. This is said, however with a cautionary note with regard to the notion of reaching a conclusion and end. In recognising the dynamic nature of the discussions embedded in this research, and the methodological approach taken, there can be no end, only continuation.

Figure1 Conceptual Framework

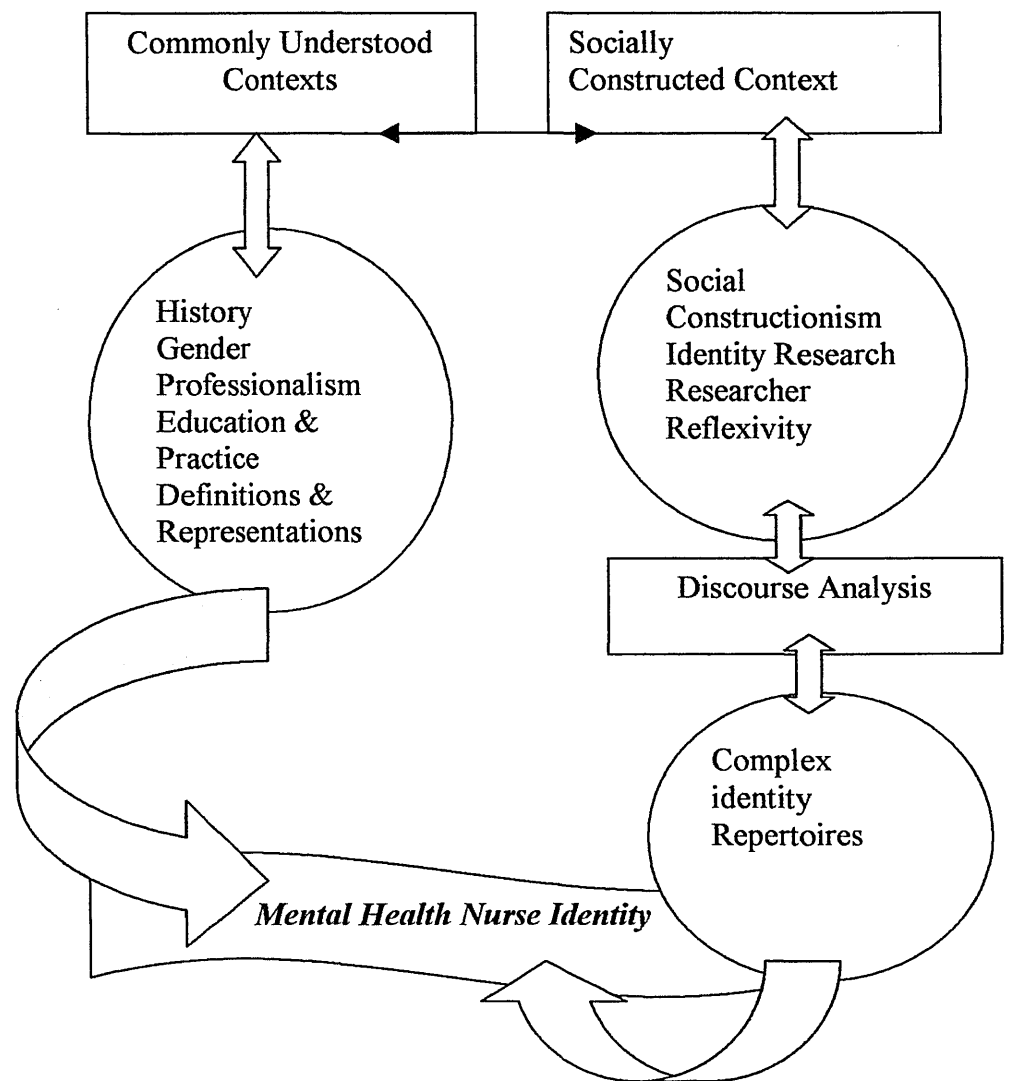


Table 1 Aims of the Research

- | |
|---|
| <ul style="list-style-type: none">• Review a range of literature that provides contextual orientation for the research• Explore and apply a social constructionist, researcher reflexive, approach to this research• Discuss the use of the methodological approach in relation to its contributing to mental health nursing research, practice, education and policy• Identify and discuss wider considerations that have arisen in relation to this research |
|---|

It is important to reiterate that the discussions that follow are this researcher's discursive repertoire. They are developed in relation to the nurse participants' constructions of 'identity' repertoires and situated in contemporary literature, research and debate related to the participants' identity constructions. It is also noteworthy, that as the discussions move forward, suggestions and recommendations are made that, in accordance with Wolcott's (1990, p.56) notion, would suit the 'occasion' of this research.

Thus the structure of this chapter is designed to present discussions that are linked to the aims of this research and in so doing the presentation of these discussions will follow that of chapter 1. First there will be a personal reflection of the use of discourse analysis as it relates to this research. This is followed by discussions that are linked to professional perspectives. In this section, key elements of the data analysis are discussed, these being the nurse participants' constructions of 'identity repertoires', as presented in the preceding chapter. Thus, the discussions related to identity repertoires that follow are not intended to categorise each specific 'identity' repertoire as single, unified representation of mental health nurse identity. Rather, these

discussions, whilst illustrating key points related to individual identity constructions, are in essence inextricably linked and at times the discussions are interchangeable. The final section in this chapter present discussion of the key research issues of this research. That is, the contribution that this study makes to 'identity research' is presented.

7.2 Personal Perspective: Reflections on a Discourse Analytic Approach

It is timely at this point to re-emphasise that there is not one single discourse analysis in the way that we would traditionally recognise in qualitative research. What is explored in this research is a broad theoretical framework that illustrates the nature of the nurse participants' discourses and ways in which they play a part in the social life of these nurses. That is, how their discourses are part of their professional identities. One of the potential disadvantages of using this approach is that it does not produce the broad empirical generalisations that are generated in other research methods. Therefore the analyses in this research cannot be understood as such. It has, however, never been proposed that they were intended to identify a universal underlying construction of professional identities for this group of nurses. What it does however, is to examine the justifications, accounts and constructions put forward by a participants from a particular social group, that is registered first level mental health nurses, in a particular context, that is, in the course of focus group discussions with a mental health nurse, the researcher, talking about what they do as mental health nurses.

The notion that there are no theoretical universal processes that emerge from discourse analysis should not be perceived as limiting or a weakness, but rather as Wetherell and Potter (1987) espouse, an inevitable result of the fact that explanations are always constructed from commonly available interpretive resources and are designed for particular occasions. As such, we should expect to find different accounts emerging in discussions related to the nurse participants' professional identity repertoires if, for example, they had been talking to a manager, a friend or a lay person. This in itself does not serve to invalidate this research, but merely embraces discourse analysis' position with regard to the constructive, constitutive and action orientated nature of language.

Another issue that must be borne in mind for individuals contemplating undertaking discourse analytic work, is the enormously steep learning curve involved for those new to the approach. The effort involved is demanding on resources, in terms of the time required for interviews, transcription and the complex analytic process. The time factor for participants is also particularly important to bear in mind when considering recruitment of research participants who are in full time employment and work on rotational twenty-four hour shifts. A further related issue is the appropriateness of the chosen location for the focus group interviews, which needed to best suit the participants needs rather than the researchers'. In addition to these practical issues is the time taken to learn and develop the necessary analytic skills. As Wetherell and Potter (1987) have reminded us and as is stated earlier in this work, discourse analysis is a 'craft skill' that requires a particular approach to reading and re-reading data. This has been

a major issue for the researcher in this research. However, it has also been a valuable experience and one that will be recommended to other researchers looking to undertake research in mental health nursing.

The benefits gained from this approach lie in its sensitivity to the participants' discourse, in as much as it is valued for what it is and not for its utility as a vessel for underlying interpretations and theorising. It facilitates the opportunity for discussion in relation to the presented evaluations of data, as discourse analytic studies include either full or segments of the analytic material. This is the case in this research. Therefore readers are afforded the opportunity to assess the researcher's interpretations of the transcribed data and to make then their own, if they feel inclined.

Finally, research studies at doctoral level are encouraged to 'break new ground' and in so doing contribute significantly to 'new knowledge'. In adopting a social constructionist, discourse analytic approach this research has provided a discourse regarding what is unique about mental health nurse identity and in the approach chosen to investigate phenomena. In their discussions, the nurse participants in this research construct their professional identity to be unique and in so doing, they produced discourses that are ideological because the accounts they produced serve to justify and perpetuate the notion that differences exist within nursing and the health care professions. To use Potter and Wetherell's (1987) position, it is not necessary to believe in a reality underpinning social phenomena in order to see that certain social relationships and accounts have ideological functions. This has been accomplished in this work.

It has been clearly presented in the nurse participant's discourses in this work that they have constructed repertoires that illustrate significant contrasting differences between themselves as mental health nurses and their general nursing colleagues. They have also used contrast structures to illustrate differences with mental health practice areas and have made use of discourses that contribute to relationship position that continue to exist between medical professionals and nurses. Thus, the analyses chapter in this study serve to provide discourses that produce subjects and objects in certain ways, for example the nurse may be rendered subordinate by a discourse that positions doctors in a particular way. Mental health nurses are constructed as not 'real' nurses in discourses that present aspects of their practice that is not readily observed or understood by others.

The notion that identity can be positioned and is also a position within discourse should be viewed positively as it provides us with new understandings of how mental health nursing is constituted. A social constructionist, discourse analytic approach offers nurse researchers a framework for understanding relationships between individuals and the social world and for conceptualising change in nurse education, albeit it must be appreciated that these are my interpretations.

Mental health nurses are frequently subject to jibes from nursing colleagues from other disciplines that they are not 'real' nurses, that they are by and large bureaucratic non-conformists who demonstrate this 'behaviourally' in their attitudes and sometimes, it has been said, in their dress. Such jibes, however 'frivolously' intended, serve to marginalize mental health nurses in a similar way that social attitudes have contributed to the marginalisation of

those with mental health problems, as has been evidenced in Cowan's (1998) work. If, as it is suggested, mental health nursing is not 'real' nursing, then its reality must surely be 'relative'. A concept that fits easily within the post modern, emancipatory domain. That is, that which intends, through its application, to shed new insights into aspects of society and people's lives. By recognising that identity is positioned as well as positions in 'discourse', the notion of what is and is not a 'real' nurse becomes an argument that claims discourses are socially and culturally produced patterns of language which construct things in different ways. Thus a nurse may be a 'real' nurse if appropriately registered to practise, or could be positioned as such within commonly accepted and more easily understood nursing discourses such as general nursing, whose focus is on care and cure, or indeed, if female, could be situated as a 'real' nurse within traditionalist discourses of gender as fulfilling her nurturing role. Therefore the discussion returns to the original position offered at the outset of this research. That is, that mental health nursing is difficult to define and its identity is complex and premised on skills that are largely 'invisible' to the observer. Thus in studying the discursive constructions of the nurse participants' talk, in this research discursive constructions of their identity have been presented that contribute to a socially constructed discourse of what it is to be a mental health nurses.

7.3 Professional Perspective: Identity constructions

The preceding analysis chapter illustrates how a discourse analytic approach can 'open up' data and produce innovative analyses of the nurse participants, in this research 'talk' about what it is they do as mental health nurses in their

discrete areas of practice. The analyses in themselves are not exhaustive and other researchers could have taken different approaches to this study. Other researchers may also have selected different accounts within the participants' talk for analysis. That being the nature of research, it is however evident that this research contributes to ways of 'knowing' mental health nursing. It also provides insights into the discursive constructions of professional identity mobilised in the 'talk' of mental health nurse participants in this research study. These are achieved by using an approach that allows the 'voices' of the nurse participants in this research to be read, and in so doing contributes to a contemporary and liberating vision that acknowledges the importance of social groups such as mental health nurses. In this thesis, constructions of professional identity have been examined in relation to how the individual nurse participants fulfil their role across a diverse range of mental health areas and with a similarly diverse client population. Rhetorical claims are made by these participants that illustrate a range of 'identities' that individually, collectively and indexically serve to justify the overarching position that mental health nurse identity is not easy to define or categorise. In particular the participants in this research use a number of commonly used rhetorical devices to construct these versions of their professional identity, such as accounting, logical argument, story telling. The participants also anticipate the kind of negative inferences that can be drawn from their construction of a 'controlling' identity. They attend to these potential problems through the discursive strategies they use, in particular by providing accounts of personal experiences, moral justification, hypothetical story telling and empiricist accounting, where they use historical evidence to

support the identity constructions they make. It is with these aspects of the participants' discussions that the wider relevance of the study rests. There follows therefore a more focused discussion of each of the identity repertoires constructed by the participants, within which reference will be made where it is considered appropriate to theoretical professional and nurse education implications as well as specific empirical implications that emerge as the discussions unfold.

The participants in this research have presented in their talk, accounts of mental health nurse identity as being different. These differences are mobilised in their contrasting accounts of practice experiences both within mental health nursing as well as between mental health nurses and their adult nurse colleagues and other health care workers. In so doing, the participants demonstrate an orientation to the complexity of mental health nursing practice and a contrasting orientation to the practices of others. This is demonstrated in the individual and collective affirmation of the 'identity as different' repertoire made by the participants, each of whom have their own story to tell in presenting their individual cases as well as assisting their colleagues in their specific 'different' constructions. The theoretical implications for this 'identity is different' repertoire are important for practitioners and nurse education. Contemporary mental health practice and education remains in the process of significant shifts in 'ways' and 'patterns' of working with clients with mental health problems. These moves have evolved in alignment with social, political and economic trends. The implications of this is that individual interpretations of the practice of mental health nursing are unfolding in ways which are not being met from a nurse

education perspective. For the individual to have an identity is to be placed in a 'category' with associated characteristics and features. For example, nurses exist as a social category with commonly understood interpretations of what a nurse 'is'. Mental health nurses exist within this social category. However the nurse participants in this research make the claim that their identity is 'different'. This difference is in relation to each other and to others performing the same overarching function that is 'nursing'. The amoebic growth of what are constructed to be 'specialist' areas of mental health practice have and continue to evolve from previously taken for granted traditional notions of what nursing 'is', such as hospital based care. This is reflected in the participants' construction of identity in this research, where they make comparisons and 'mark territory' between each other across their practice areas and focus their practice more centrally on the needs of individual client groups, such as those whose mental distress is acute, those for whom mental disorder is persistent and enduring. Thus, mental health practitioners are defining the boundaries of their practice in apposition and opposition to each other. As such, the 'identity as different' construction is rhetorically presented in relation to their individual and collective perceptions of the role they are fulfilling at a given time in their career experience with specific client populations. The force of this 'identity is different' repertoire is in the interaction between the nurse participants. However, recognition of the plurality of mental health nursing at all levels of practice must be a central tenet of mental health nurse education and practice. The participants in this research present mental health nursing as being both fundamental and specialist. In so doing, this raises the notion that there is no one tool for the

job. The fundamental skills of mental health nursing in the participants' talk are presented in a way that allows some existential licence in how these skills may be applied in different contexts. Coupled with this are accounts of particular and specialist knowledge and skills that are required to work with clients across the wide range of practice areas and diverse client populations across the life span. From an educational and practice perspective, the awareness of different ways of working, should not simply be at the 'obvious' end of the spectrum, that is, the steady shift from institutional care towards community care and a primary care led service provision. Evidence of diversity of practice within practice areas that are seen as 'traditional, such as wards and units within existing institutions and day hospital settings, must be given appropriate recognition. Appropriately aligning mental health knowledge, skills and practice with individual client population needs will produce a more effective service, greater quality of client care and nurses who are experts in their field of mental health nursing. Practitioners working with children and adolescents are required to have expertise and awareness of issues such as deliberate self-harm and suicide in young people, early years episodes of depression, alcohol and substance abuse. Alongside this they require an acute awareness of the experience of family and social life. At the other end of the spectrum, the well being of older adults is a major social health concern. Of particular concern is the mental health of an increasing population of older people alongside the physiological problems associated with aging. This poses a problem in terms of provision of efficient and efficacious care for this client group. Those working with older adults and their carers need skills and knowledge of the normal processes of aging as

well as the potential mental health problems associated with these client groups. This includes knowledge of cultural diversity, grief and loss as well as suicide risk. The nurse participants in this research working within community services make a strong case for the diverse range of knowledge and skills required for this role. These include socialising, assessment strategies, advising, awareness of family dynamics, liaison skills, education, counselling, crisis intervention and human caring. The impact on this for nurse education and practice suggests that in order for nurses at the point of registration, to meet the broad range of knowledge and competencies for practice, an age continuum approach to curriculum development would ensure that issues related to each of the 'lifespan groups' are embedded in initial nurse education. However, there are limitations to the volume and extent to which each individual aspect of mental health nursing can be adequately dealt with at undergraduate, pre-registration level, within a three year programme that is structured around a common foundation level year and two years for 'branch' related studies. Thus, it is proposed that there is a need for deeper level, research based, high quality specialist and advanced nurse education in child, adult and older adult and other mental health specialties at post-registration/post-graduate level. This issue will be taken up further in this chapter.

Alongside differences in practice across the age span of clients, mental health nurses are, more than even before, required to engage with clients who present with complex and challenging problems that may affect their mental well-being. One of the participants in this research tells a hypothetical 'story' of their experience of working with survivors of sexual abuse and the

complex issues that ensue for new nurses in practice when met with this potential challenge. The theoretical imperative in this situation is the need for nurses to be appropriately equipped with a tool-kit of knowledge and skills that will allow them to engage in the therapeutic care of both victims and survivors. With the emphasis on a community primary care focus in contemporary practice the role of community mental health practitioners has also become more complex and challenging and there is a range of 'different' identity constructions within this area of mental health practice. Not least this involves the challenges faced in their work with clients with severe and enduring mental health problems. In particular, the emphasis of community mental health nurses having a public health role is unique and challenging and embraces knowledge and skills in family interventions and case management working with non-psychotic service users. Extending this community role to include working as a mental health practitioner in general practice embraces the Government's new agenda. However, the difference becomes more complex when the role of the mental health nurse transcends commonly understood boundaries and ventures to areas that are both controversial and extreme. These include the work of mental health practitioners in the challenging area of forensic mental health practice. The nurse participants in this research caution that the role of mental health nurses working in this area creates a dichotomy between social control and care. With an increase in knowledge and a demand for more appropriate and efficacious approaches to the care, treatment and management of clients with mental health problems, the skills and knowledge required by these practitioners have also become more complex. Nurse led therapeutic

intervention initiatives must become part of the curriculum for mental health practitioners in a more robust and managed way than ever before. It is no longer the case that a 'flavour' of a range of therapeutic interventions is sufficient to equip contemporary practitioners. If mental health nurses are to be at the leading edge of practice, there will have to be appropriate client focused education and training that prepares practitioners for their work with discrete client groups using specialist knowledge, research based skills and therapeutic intervention techniques both at initial education level and beyond. The empirical position in this research would suggest that what is wrong with mental health nurse education at present is nurse education.

In the preceding discussions, it is apparent that the nurse participant's constructions of their identity as 'different' recognises the diversity of health care *per se* and mental health practice in particular. This diversity is the driver for a slow and steady surrender of 'generic' psychiatric nursing. Practitioners who undertake pre-registration programmes cannot realistically meet contemporary demands. The challenges posed by these developments include a shift in organisational culture or both mental health nursing as a profession and the education system that prepares other nurses.

These discussions have also identified that there are differences in practices across hospital based mental health areas as well as across the spectrum of community orientated practices. Moreover, the ways in which education programmes for this group of nurses are organised and managed need a complete review. It is no longer appropriate to attempt to cover such a complex and diverse subject as mental health nursing in a basic nursing programme. The nature of the client groups and their presenting difficulties

as well as their chronic problems are diverse, complex and challenging. Further discussions regarding education and practice follow later in this chapter.

The participants in this research make a case for mental health nurse identity being complex. In order to achieve this, they make claims with regard to the complexity of the client groups that they work with and the range of knowledge and skills required to practice mental health nursing. The complex nature of mental health nursing is reflected throughout this research. The participants' accounts of unpredictability and impulsivity of many clients with mental health problems add to this complexity. Apart from the diverse range of knowledge and skills that the participants claim are needed to practice mental health nursing within this complex health care world, they also profess a need to embed within this profession a system of support for practitioners that allows them to share and reflect on practice with practice mentors. Much of the 'life trauma' that triggers mental health problems and extreme behaviours challenge understanding for many individuals. If nurses are to be knowledgeable, skilled, empathetic and therapeutic in their relationships with diverse and challenging client populations, there needs to be systems in place that allows them the opportunity to discuss their practice and concerns. This requires a culture shift in nursing practice, more research in the benefits for practitioners of reflective practice and developments in the existing clinical supervision systems in operation in some areas of mental health practice.

That mental health nurse identity is complex is apparent from the participants' discussions. The ways of mental health working, and the extent

of the knowledge and skills required to fulfil the role of mental health nurses within this complex arena, are supported in other discourses that position this complexity in relation to risk, stress and challenging work environments.

The nurse participants' construction of identity as determined by others was developed using accounts of media representations of mental disorder and the use of 'situated others who, as the nurse participants' propose 'think that we do nothing'. There is empirical evidence that mass media representations are informing the public about mental illness through their representations on a frequent and regular basis. These representations are generally unfavourable and heavily play on the extreme behavioural aspects of mentally ill individuals.

However, it is not only media representations that contribute to attitudes towards mental illness and those who work in this field. Particular stereotypes within the health care professions affect the ways in which professionals and lay people view mental health nursing. This is evidenced in the accounts of practice experience presented by the participants in this research. Thus the need to have a focus regarding professional identity may assist in alleviating this problem.

These discussions regarding the nurse participants' construction of mental health nursing as determined by others can be linked to other discourses related to attitudes towards the mentally ill and those associated with this client population. However, it should be remembered that attitudes are in themselves discursive resources that people use to make a point or take a position on things. This may place some understanding on media

representations, where story lines that are extreme will increase viewing figures and readership.

It may well also be the case that professional chaos in terms of health service reform, change and uncertainty, the ideology of institutionalisation, and health service funding crises, contribute to negativity in mental health nursing practice and across the health care sector in general.

The nature of mental disorder and mental health practice has been presented by the participants in this research as both different and complex. This particular identity repertoire serves to open up a perennial debate regarding public knowledge and awareness of mental health and mental ill health. The practice of mental health nursing is also controversial from a legal, moral and ethical perspective.

In this research, the nurse participants' discursive construction of mental health as being 'custodial and controlling' was mobilised in their accounts of practice experiences where issues of client and public safety and risk were presented. It has been discussed that the diverse and complex nature of mental illness and mental health practice embraces nurses working in challenging situations with clients who may well pose a risk to themselves or others. One of the key elements of any programme for mental health nursing is the inclusion of strategies that ensure mental health nurses are equipped with the knowledge, skills and expertise to meet this practice requirement. All pre-registration programmes in the United Kingdom address this professional requirement, albeit there is no clear articulation across programmes regarding how this is taught and how competency in this domain is achieved. Balancing care and control is a sophisticated skill, and mental

health practitioners need to be aware of their therapeutic role as well as the potential custodial aspect of their engagement with clients and the impact that this has on the therapeutic relationship. Mental health practitioners have the potential power to subjugate patients in working practices that are shrouded with legal constraints. In this research, examples of the potential for this is presented in the participants' accounts, where they discuss the use of the Nurses Holding Power section of the Mental Health (Scotland) Act 1984. However, legal constraint is only one aspect of the custodial and controlling repertoires constructed by the nurse participants in this research. They also present a case for the system itself being controlling.

In addressing the need for mental health nurses to be aware of the multiplicity of issues that are embedded in this 'identity as controlling' construction, nurse educationalists and practitioners must devote more care and attention to moral, ethical and legal issues related to practice, revisit historical perspectives and theories of mental illness, and generate research based and informed debate on contemporary social policy with regard to working with vulnerable client populations. It should also make explicit the extent and implications for the role of the mental health nurse in ensuring client and public safety and patient rights.

The discursive repertoire in the nurse participants' talk constructed identity in relation to the role or functions that these nurses performed in their every day work. These included micro and macro role constructions that embrace day-to-day activities as well as more discipline specific roles, such as community mental health practitioner, working with clients with enduring mental health problems and others. Thus, the discussions that follow will cover this

micro/macro debate as it relates to education and practice issues in mental health nursing.

Psychiatry has waxed and waned over the years, and with these shifts interest in the ways in which people work with clients with mental health problems has become a perennial research concern. In earlier chapters of this research the historical development of mental health nursing was discussed as was the work of nurse theorists researchers such as Peplau (1952). It can be argued that her work on 'work-roles' of psychiatric mental health nurses has been the benchmark for subsequent debate regarding what it is that mental health nurses do as nurses. Looking at this list of work-roles, and reading the transcripts of the nurse participants in this research, it could be argued that little has changed over the years.

Within the constructions by the nurse participants in this research claims are made that their knowledge base is wide and diverse. It is also claimed that it not only encompasses traditional medical/technical knowledge but that their practice requires them to draw on wide socio-economic issues that impact on mental health and ill health issues. They develop an argument that challenges formal education processes and acknowledges experiential learning and learning from role models. There is also an account of the functional role of education as the gatekeeper that allows them to become a registered first level mental health nurse. Subsumed within this discourse is the experience of the learner in this process.

Given the discussions that have taken place in this chapter thus far, it would appear that 21st century nurse education has not moved far in this domain. Issues that generate from the nurse participants' talk in this area are wide and

complex. They challenge the core of mental health nurse education. These include recruitment and selection processes for both pre-registration and post-registration programmes, their design, content, delivery and evaluation. Coupled with this the role of practice as a vehicle for effective clinical skills acquisition and the student experience are also presented as problematic. The professional and educational debate here appears to be about what exactly 'is' mental health nursing. And how can nurse education efficiently and effectively serve practitioners in this field. This research has shed some light on these issues by asking those who do mental health nursing to talk about what it is they do and how they acquire the knowledge and skills to work in this challenging area of health care. The challenge for the profession and educationalists is to listen to what they say. Implications for policy are presented later in this chapter.

Within the nurses' 'talk' in this research, the case is made for self-knowing and honesty as being important for them in their practice. The concept of self-awareness in nursing is not new and indeed in many pre-registration programmes is covered as an integral part of the common foundation syllabus. However, this area of personal development could be more overtly adopted throughout mental health curricula at pre-registration and post registration levels.

The preceding discussions have highlighted that mental health nurses' identity, as constructed by the nurse participants in this research, is a complex amalgam of identities. The participants' identity constructions have made it clear that there is much to be done in terms of recruiting, selecting and preparing individuals to work in this complex field of nursing. They have

also served to justify the approach taken in this research as being an appropriate contribution to mental health nurse identity research. The following section addresses this area more specifically.

7.4 Research Perspective: Discourse Analysis and Identity Research

In taking a social constructionist, discourse analytic approach this research has contributed to the growing field of identity research that embraces the notion that identity is mobilised by individuals in the commonly used discursive devices used in every day talk. The importance of this approach being the shift from describing mental health nurses in a particular way to illustrating how mental health nurses identity is made relevant to the individual participants in this research. Thus identity becomes a resource for the participants in this research rather than a tool for the researcher. Thus the focus is on what and how identity constructions are mobilised to achieve particular goals for the participants. This takes mental health nurse identity beyond the notion that there is one single universal version out there of the mental health nurse that exists as a marker for that professional group within nursing. What this research has attempted to do is explore how mental health nurses in this research use the identity constructions rhetorically to make the case for mental health nursing being complex and unique to the individual practitioners and the clients and client groups with whom he/she works. In other words, the concern is with the occasioned relevance of mental health nurse identity in this particular research, and how the constructions of

identity are consequential for these particular practitioners in the interactions that took place in the focus group discussions.

Thus the purpose of this research was not to define mental health nursing in any particular normative category but to allow the participants an opportunity to make use of the discursive resources available to them to construct their identity. Thus allowing the normative resource of 'being a mental health nurse' to be simply that, a resource that the individual participants have employed in their talk as they rhetorically justify, describe, excuse and make claims about their identity. In so doing, discourse analysis in this research avoids getting embroiled in the ontological status of mental health nurses by treating the 'reality' of mental health nursing as the concern and accomplishment of the participants. Thus the process of affirming or rejecting mental health nurse identity repertoires in this research are negotiated in the talk of the participants. In so doing, this research serves to provide a more integrated and dynamic view of mental health nurse identity. It has achieved this by adopting the position that the variation in the accounts presented by the participants in this research are more important than more traditional single representation of mental health nurse identity. That the participants' talk in this research is more than simple transmission of information about mental health nursing. Finally, the participants' identity constructions in this research are the product of culturally available repertoires; adopted, refashioned and refined to serve the purposes of the participants in this research.

Thus the 'voices' of the participants in this research contribute to greater awareness and insights into the individual identities of mental health nurses.

7.5 Policy Considerations

This research has implications beyond the level of academic debate. As highlighted in chapter two, contemporary nurse education programmes are designed to prepare practitioners appropriately for entry to the professional register. In so doing, these individuals are considered to be ‘fit for practice and fit for purpose’. It is clear in the individual nurses’ discussions in this research that initial preparation for the demands of their role continues to be problematic. There are a number of issues that have been raised in the nurse participants’ discussions in this study that have implications for policy in both higher education in general and nurse education specifically. The first of these is the position that the participants in this research take in the development of the argument for a more mature entrant on the basis of the challenges that working with people with mental health problems bring. The second issue is the strong emphasis in the participants’ talk with regard to nurses in this field being self-aware and able to reflect on and in practice, highlighting the importance of practice based learning. There are also aspects of the educational provision for their role, that they take issue on in this research. In particular they make a strong case for more appropriate and focused education and training in areas that would best serve the diverse particular practice needs of this discipline.

Whilst there may be a case for recruiting more mature individuals into this particular branch of nursing, this may not necessarily address the issues raised by the participants. Their main claim for this approach is the lack of

life experience and ability to cope with difficult and sometimes dangerous situations in practice. However, there is a position with regard to facilitation of mature University entrants into a system that predominantly centres on a student population that is recruited mainly from schools and in the main delivers full time study. Current higher education policy espouses the notion of widening the portals of entry to higher education and promotes the concept of life-long learning. Nurse education is in favour of a more family friendly approach to nurse education. However the move to a structure for pre-registration programmes that is less rigid has been slow and fraught with bureaucracy. Key issues that need to be addressed if we are to recruit more mature students include grant and bursary funding arrangements, appropriate student support, crèches and after school clubs and programme design and delivery.

In addressing issues two and three above, a more radical approach to mental health nurse education must be addressed. The surge in new role developments in nursing including across the spectrum of mental health practice require professionals to be creative in the use of existing skills as well as to develop research expertise, new knowledge and new and challenging ways of practice in accordance with the UKCC's recommendations. The emphasis on much needed changes in mental health services require staff to learn to work in different ways. They must meet the challenges of working with other health care professionals; the voluntary and independent sector and social services to provide the range of health and social care provision necessary for clients. They need to maintain and build on the progress made regarding service users and carers' involvement in the

development of services and in curriculum and evaluation of practice. For some specialist areas, such as forensic psychiatry, rehabilitation, and community mental health, specialised learning opportunities need to be developed.

As nursing is both an academic and a practice profession, the pressing challenge is to develop a model of inter-agency working which resolves the historical dissonance that has existed between the health care professions and between practice and education. As change impacts on education and practice, collaboration may no longer be an option.

The current challenge for nurse education has to be the need to prepare nurses who are 'fit for purpose' at initial registration level and beyond. That is, that they should be equipped for their professional role with the necessary knowledge, skills and confidence to function effectively with their individual clients and client groups, peers and their professional counterparts. To achieve this requires strategic policy based on research that acknowledges and learns from the past, is visionary with regard to the future and which listens to the 'voices' of those for whom it serves.

One solution would be to offer a longer and more intensive practice focused direct entry mental health programme of study. This would provide the basic building blocks for practitioners who would then choose a specialist education route at post graduate level in knowledge and skills specific to the range of clients and client groups that use this service. Nurse education has had many opportunities over the years to produce innovative and creative educational provision for health care practitioners. It has however, more often than not, failed to achieve this goal. It has failed because it cautions

against radical change and simply reinvents the *status quo*. Educational provision that continues to emanate what currently exists will not provide mental health practitioners or clients with the competent and confident workforce that is needed for contemporary mental health practice. The major illness that affects those working in and receiving mental health care is nurse education that is simply 'more of the same'. Thus a fundamental shift in the way in which nurse education organises, plans and prepares its practitioners is proposed in this research. One in which direct entry to mental health study provides the foundation and building blocks to post graduate specialist mental health education and practice. One in which shared education with those professionals whose roles and functions are a 'best match' to mental health practice, such as social workers, clinical psychologists, occupational therapists and psychiatrists. This would ensure that multi-professional and inter-agency education and practice is systematically organised with the best interest of practitioners and service users as its core, a programme that is rooted in self-awareness, interpersonal skills and therapeutic skills development from the outset, with students being reflective in their personal, educational and practice developments; and an educational process that puts the student at the centre in a similar way to practice placing clients at the centre.

Moreover, we must offer frequent review and career guidance from academic and clinical mentors as they progress through their studies and practice experiences as a means of assisting in personal and professional growth and enabling students to make the most appropriate career choice within mental health practice on graduating.

Thus the educational programme and approach proposed here requires policy makers to rethink nurse education as a whole and mental health nurse education in particular. It requires a rethink of the professional registration to practice that moves it from simply one initial registration entry to a more flexible register of specialist mental health practitioner entries. As a society, we have long surpassed 'one size fits all' concept, where one mental health nurse can meet the complex needs of the spectrum of mental health clients in to-day's world, at the point of initial registration. Clients will be better served by this approach. Attrition rates may well decline as a result of a more motivated workforce, placed in areas where they are skilled and confident to practice and who can see career horizons.

It is research such as this, where nurses truly are provided with a 'voice', that provide the resources needed to support meaningful policy reform.

Finally, from a nurse and an educationalist, it is proposed that this research has contributed in a meaningful way by exploring the complexities that are mental health nursing from a different perspective. Traditional views of what constitutes this area of nursing, and what are notions of registered first level mental health nurses' identity are simply one-way of knowing.

7.6 Conclusion

Within this chapter, the findings and implications of this research have been presented. In revisiting the aims of the study and presenting discussions that link the analytic outcomes to these aims, this research reaches what is presented as a conclusion. There has been a great deal to learn at a personal reflective level in the completion of this work, as indicated at the outset of

this chapter. The identity repertoires constructed by the participants serve to illustrate the complexity and uniqueness of their identity. In this research a greater understanding of how difficult it is to neatly compartmentalise what it is that mental health nurses do has been made evident. Their accounts of their work across a range of clinical areas and with complex clients and client groups provide insights that explain how difficult it is to make one single universal position on this role. The consequences of this for education and practice are crucial to taking this particular field of nursing forward in the future.

This research has illustrated that being a mental health nurse is a unique and individual experience and is positioned within an equally complex health care system and with clients and client groups that contribute to this complexity.

The discourse analytic approach adopted in this work places this research clearly within the domain of identity research that recognises that identity is dynamic, and that it is rhetorically and socially constructed. It is also clear that in a profession that has interpersonal communication as its core skills and with clients whose 'realities' are unquestionably discursively constructed, the research approach adopted in this study is the most appropriate to develop insights and awareness into this complex field of healthcare practice. This chapter also proposes policy reform in relation to nurse education. In addressing this need, the Government's position on clinical governance will be more appropriately achieved. In attending to the proposals in this research for a more selectively focused vision for interdisciplinary mental health education the Government's concern with retention and recruitment may be positively influenced. In ensuring that

mental health nurse practitioners have appropriate pre registration and postgraduate education, the Government's agenda for Mental Health Review will be more successfully achieved. Thus this research is valuable at a professional, academic and policy level.

Chapter 8: The Thesis: Concluding Remarks

8.1 Introduction

8.2 Summation

8.3 Strengths and limitations

8.4 Conclusion

8.1 Introduction

In bringing this research to a point of closure, this brief chapter presents summary remarks related to the academic nature of this work. In undertaking this research, the researcher proposes that a research approach has been adopted that is both original and creative. It is further proposed that this work has contributed to the body of knowledge that is mental health nursing. In so doing, this work provides insights that may inform policy, nurse education and practice and thus enhance quality of care for those who experience mental health problems.

8.2 Summation

This research, whilst acknowledging the plethora of research on mental health nurses, has been unique in terms of the social constructionist, discourse analytic approach taken in the study of mental health nurses' identities. In adopting this approach, this researcher has explored an important topic from an unusual stance. Adopting this approach is timely both from a research perspective as well as mental health nursing perspective. This approach leads one to accept the broad theoretical framework concerning the nature of language and the role it plays in social life. In a discipline that has language use as its core key skill, the study of language and its function is a major contribution to knowledge in this area of nursing. The discourse of this research serves as a 'voice' for mental health and mental health nursing practice. In so doing this research approach offers visions for making worthwhile political interventions that impact on nurse education and practice. Constructions of the complexity of mental health

nursing, the knowledge and skills required to function as a mental health nurse and the challenges for practitioners in working with clients with mental health problems are central to the discourse in this research. Thus, this research has produced a 'new' discourse on mental health nursing. Policy does not reside in a vacuum in written documents and reports. It is 'actioned' in practice by individual nurses. Thus, the nurse participants' discourses in this study contribute to knowing mental health nursing and that knowing contributes to the development of knowledge that informs policy and education. From another perspective, this research also contributes to the growing area of social constructionist, discourse analytic identity research. In so doing, this research highlights a discursive synergy between the research topic and the chosen methodology. This research stemmed from the premise that mental health nursing was difficult to articulate. The process of analysis in this work serves to acknowledge that this is indeed a complex and dynamic area of nursing practice. This research also illustrates the reflexive role of the researcher in the research process. In so doing, it identifies an aspect of the role of the researcher that is unique and unusual. Embracing this position, the discussions that follow will concentrate on reflecting on the strengths and limitations of this research.

8.3 Strengths and limitations

All discourse analysis is time consuming and labour intensive in relation to organising, undertaking and tape-recording and transcribing focus group discussions. The functional aspect of the discourse analytic process is discussed earlier in this work; therefore suffice to say that this approach

required the researcher to develop new skills and the motivation to continue with the study. It was a steep learning curve, but one which has been rewarding. Discourse analysis has also suffered extensively from the 'so what?' syndrome in relation to individuals' different discourses. In the case of this research, the 'so what?' issues in relation to the mental health nurse participants' discourses and the researcher's discourse of their discourses remains the business of the reader to determine. It is not claimed in this research that one single uniform definition of what is a mental health nurse is presented; rather the construction of mental health nurse identities in this research is one researcher's analysis of available data. It is for the reader to determine that the presentation of analysis in this work serves to fulfil that remit. There will be some who would say that the number of participants in this research is significant in terms of the small number involved. Again, in discourse work this is not an issue. It has been made clear in this research and in that of others that the importance is not in the number of individuals who make a case for one identity construction or another, rather it is in how these identities are rhetorically constructed by the individual participants using culturally available resources.

Thus, the strength of this work is in the approach. One of the main advantages of a discourse analytic approach in researching nurse identities is that the data are everywhere. They are to be found in conversations, consultation papers, written texts, the Internet and on television. In the case of this research, the participants were readily accessible to the researcher and were willing and eager to talk about their every day working lives. Thus, the focus group discussions that took place were the participants' discourses about their own

practices as mental health nurses. The transcriptions were not used to determine what they 'actually' did or how many of them 'actually did it', or 'how often'. What was important was to look at the claims being made and disputed by the participants and how these were worked up in their talk.

The researcher proposes that this is a research approach that fits the purpose of mental health nurse research. It is liberating for participants in that it accepts that what is said is the case. In so doing, an emancipatory opportunity for participants is provided that other research approaches do not.

8.4 Conclusion

Thus, in concluding this research, it is proposed that in undertaking this study an important contribution has been made to mental health nurse research and practice. It is further proposed that the methodological approach taken in this research is a useful model for other researchers to employ when investigating complex phenomena. Finally, the researcher suggests that it is the case that research of this nature is and should be influential in the development and implementation of health care policy and policy related to nurse education.

Glossary of Terms

Registered First Level Mental Health Nurse:	A nurse who has undertaken study in accordance with statutory requirements for entry to Part 13 of the Professional Register
Mental Health Nurse:	A practitioner who works with clients/client groups with mental health problems either in institutional settings, day hospitals or in the community
Psychiatric Nurse: Adult Nurse:	As above the terms are used interchangeably A practitioner who works in a general nursing environment with individuals with clients who have physical health problems
General Nurse: NBS	As above, the terms are used interchangeably National Board for Nursing Midwifery and Health Visiting in Scotland
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
Common Foundation Programme:	The initial 11/2 – 2 years of pre-registration nurse education that is common to all areas of nursing practice
Branch Programme:	The concluding 11/2 - 2 years of nursing study that is specifically focused to the individual nurses chosen branch of nursing i.e mental health, adult, child, learning disabilities
HEFC	Higher Education Funding Council
SHEFC	Scottish Higher Education Funding Council
QAA	Quality Assurance Agency
NHS	National Health Service
UK	United Kingdom
WHO	World Health Organisation
DoH	Department of Health

Note

During the process of this research there have been changes to the way in which the nursing profession is regulated. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the 4 regional National Boards for Nursing, Midwifery and Health Visiting (NB) became obsolete in April 2002.

These have now been replaced by the newly formed Nursing and Midwifery Education Council, which acts as the single unitary regulatory body for nursing within the United Kingdom. The NB for Scotland has now been reformed and is now situated as a unit within the Scottish Executive as National Health Services Education Scotland (NES).

At the present time, there are no changes in the ways in which these organisations operate in relation to their role in the regulation, quality and standards of provision of nurse education in Scotland. As such the discussions within this research remain valid.

Appendix i

Phd Focus Group Topic Schedule

Interviewer

Thank you for agreeing to participate in this discussion. It is part of my research exploring mental health nurses' identities. I will be recording this on tape and subsequently transcribing the conversations which take place and wish to reassure you that matters related to confidentiality will be maintained throughout the study.

I have indentified some areas which might be useful in the interview and will go over them before I begin to tape the discussions, in order that you agree and are comfortable with the situation. I may 'come in' and ask you to expand on issues at some points, but in the main I would like you to you talk as freely as possible around the key points.

After the interview has been transcribed, I shall let you see the transcriptions in order that you can validate that they are accurate accounts of this discussion.

Key areas that I hoped to cover in these discussions as follows, I may add prompts to assist in the discussion and encourage you to express your ideas as fully as you can.

a. Describe what you do as a mental health nurse in your own areas of practice

Questions what is meant by practice = the mental health area you work in

Issues about grade or seniority = all of the things which you do as a registered mental health nurse as part of your daily work as a mental health nurse

b Tell me about the role(s) you undertake in your work as a mental health nurse in your own areas?

Questions what is meant by roles = all of the 'hats' you wear in carrying out your job

c What exactly is unique or special about your role(s) as a mental health nurse ?

Is it different, if so in what way?

d How would you define mental health nursing ?

If it is difficult to define, try and give as good a description of mental health nursing as you can

f What specific knowledge and skills are required to fulfil your role(s)

g How do you develop the knowledge and skills required to meet your professional role requirements ?

What role does education and training have in the acquisition of knowledge and skills ?

Is there any other way in which you have gained knowledge and skills necessary for your role ?

h Are there any other aspects of this topic area which you feel have not been covered and you would like to raise ?

Is everyone comfortable ? Are there any questions you want to ask before we begin ?

Appendix ii

Conference papers and publications generated from this research study:

Leishman, J.L. (2003) 9th International Qualitative Health Research Conference, *Discourse analysis and mental health nurses' identities* Guadalajara, Mexico, 26th February – 1st March 2003

Leishman, J. L. (2002) INDEN Qualitative Research Conference in Health and Social Care *Mental Health Nurses Identity: The Case for a Social Constructionist Discourse Analytic Approach* 10th – 12th September, 2002. Bournemouth

Leishman, J. L. (2002) *Mental Health Nurses Identity: a discourse analytic study* The 8th Qualitative Research Conference, Banff Canada, 28th April, 2002

Leishman, J. L. (2000) *Registered First Level Mental Health Nurses Discourse Analytic Construction of their Professional Role* Nurse Education Tomorrow, 8th October, 2000

Leishman, J. L. (2000) *Registered first level mental health nurses construction of their professional identity* 3rd International Conference of the Global WHO Collaborating Center for Nursing Midwifery and Health Visiting, Manchester 26th July, 2000

Leishman, J. L. (2000) *Nursing and Healthcare Education into the 21st Century* 3rd FINE International Conference on Nurse Education, Netherlands 8th June, 2000

Leishman, J. L. (2000) *Key issues facing Higher Education and the NHS and their Impact on nurse education* NBS Service Education Partnership Conference: Collaborative working; resolving the issues in health and social care, Edinburgh 13th March, 2000

Cowan, S. and Leishman, J. L. (1998) *Demystifying the mysterious: a workshop on discourse analysis* Network for Psychiatric Nursing Research Oxford, September, 1998

Publications

Leishman, J. L. (1998) Registered first level mental health nurses discourse analytic construction of their professional role *Journal of Psychiatric and Mental Health Nursing* Vol. 5

Leishman, J.L. (2002) Mental Health Nurses Identity: A Social Constructionist Discourse Analytic Study *Journal of Graduate Research On-Line* [paper accepted July 2002]

Appendix iii

Government Papers and Policy Documents

(this list is not exhaustive)

Department of Education and Employment (1998) *The Learning Age: A renaissance for a New Britain* London: Department for Education and Employment, (CM3790)

Department of Health (2000) *A Health Service of all the talents: Developing the NHS workforce*, Consultation Document on the Review of Workforce Planning, London: Department of Health, April 2000

Department of Health (2001) *Working Together Learning Together – A Framework for Lifelong Learning for the NHS*, London: Department of Health, November, 2001

Fryer, R.H. (1997) *Learning for the 21st Century: First Report of the National Advisory Group for Continuing Education and Lifelong Learning* London: Report PP62/3/31634/1297/33 n.p. November 1997

HEFC (1996) *RAE 2001 Research Assessment Exercise in 2001* London: HEFC Publication

HEQC (1996) *Academic Standards in the approval, review and classification of degrees*, London: HEQC publications

HMSO (1997) *The National Committee of Inquiry into Higher Education in the Learning Society: Report of the National Committee* London: HMSO, Chairman Sir Ron Dearing

Scottish Executive (2000) *Our National Health – A Plan for Action. A Plan for Change*, Edinburgh: The Stationery Office

Scottish Executive (1999) *The Review of the Public Health Function in Scotland*, Edinburgh: The Stationery Office

Scottish Office (1999) *Towards a Healthier Scotland – A White Paper on Health* Edinburgh: The Stationery Office

Scottish Office (1998) *Acute Services Review Report*, Edinburgh: The Stationery Office

Scottish Office (1998) *Designed to Care – Reviewing the National Health Service in Scotland*, Edinburgh: The Stationery Office

Scottish Office (1998) *Modernising Community Care: an action plan*, Edinburgh: The Stationery Office

Scottish Office (1998) *The Human Resources Strategy: Towards a New Way of Working*, Edinburgh: The Stationery Office

Scottish Office (1997) *The Regulation of Nurses, Midwives and Health Visitors: Report on a review of the Nurses, Midwives and Health Visitors Act 1997* Conducted by J. M. Consulting Ltd., Bristol, for the UK Health Departments

QAA (1998) *Higher Quality* London: QAA for Higher Education Publication

UKCC (1999) *Fitness for Practice*, London: UKCC The Commission for Nursing and Midwifery Education, Chair Sir Leonard Peach

PhD Focus Group 1

Nurses from local in-patient acute mental health and long stay mental health areas

1. male nurse (long stay area)

2 female nurses (acute area)

Average age 30 years

Interviewer

Q: Describe what you do as a mental health nurse within your own area of practice ?

Jo: Everyone happy enough to talk about what we do in our own areas ?

Mo: Maybe that would be a bit different between what you do in your area and what we do in ours there is a difference between the type of nursing you do and the type of nursing we do.

Jo: Just before you spoke there I was thinking about, you know, eh, its quite new and unique, eh, to be working as a staff nurse and in the long term care setting eh, where I am just now, eh, I am very much aware that historically the work that we do, that nurses eh do in psychiatry is pretty much custodial and I'm working alongside the legacy of that to this day. It's awkward at times and it's always questioning what my role is

Flo: Have you been able to come to any conclusions about that since you started up there ?

Jo: Yeah, yes and no. Well sometimes you've got to pretty much prioritise You know if you like things done a certain way or you want your care plan executed in a certain way, hopefully with your patient working alongside you
eh, it's not always the case that you can do that. Em, like I say, you've got to prioritise and get the essentials done which means doing a lot of non-nursing duties. As I see it on a day to day basis, the essentials are making sure the lads that I'm in charge of or who are in my care eh, make sure they are organised for the day, they're clean and comfortable; they're fed and groomed; they can chat about any problems they can see they have throughout the course of the day, make myself available to do that. It's not always they case that they see that they have problems. Em, you know we perceive that they do whereas they perceive that they don't

Mo: We don't often have,...occasionally we do have to ensure that people get up, get washed and make sure that their physical needs are taken care of if they're in a condition that they can't do that for themselves and need some assistance for that. I think more often the care plans don't need to take that into consideration the sort of tasks that you're describing. Eh, because our clients are able to do these things for themselves Em.. so that's not going to be priority for us.. daily.... where it is with you. So I think that in that in this area the roles are very different.

Interviewer

Q: tell me about the role(s) you undertake in your work as a mental health nurse?

Flo: Eh, mm...it's a very multi-factorial role we have and it can be different for different clients that you have. To one client you can be something to another you're totally different so you have to be able and prepared to change your role as it's required. You may need to take a supporting role; a problem solving role...em.. there's lots of different facets to your role.....

Flo: A lot of people we get admitted to the ward, their problem, if you like, could only be described as a situation crisis. It's a bio-psycho-social thing psychiatric nursing it's not just physical so their problems can come into any of those areas. And usually it's in all three, but it can be predominantly in one and let's say they have a situation crisis, some sort of stress factor in their environment that has contributed to... in a detrimental way to their mental health, there you would have supportive role

Flo: Em.. debts.... you know..money factors... getting in debt

Mo: Relationship problems

Flo: Relationships is usually one of the kinds of things.....

Flo: You basically just sit down with the client and eh try and gain as much information as possible from them.... regarding the circumstances surrounding what they see it as.....Also talk with the family.. if there be a family... you know to gain their information as well, you obviously find that they're usually rather different..you know... and then you just sit down and work it out with the client... you know ... and go through...you're basically there for them to talk to

Mo: eh..eh.... help...help them to suggest ways or different solutions for their difficulties, for their problems

Flo: Mmm.. sometimes just sitting down with the family

Mo: Sometimes listening.. With the family, you know, bringing the family together. Sitting their helping them. You know, a lot of them can't communicate with one another, just basically screaming and shout at one another and you're their just to step in if need be. It helps them to

Jo: In the area I work in I've been able to ease myself into the role because eh... 63 ' ' ' ' unlike the acute ward here where the girls are they've to try and obtain a holistic picture of their client within a very short space of time. .. whereas I see myself, when I first started as a staff nurse in the long term ward I had to learn a lot of administrative duties immediately and ... I took a wee bit more time to get to know the lads.. you know that I look after...and you know their families and so forth.... em.... so it's pretty much different. The majority of our lads... they're grossly thought disordered...constantly..... apparently preoccupied by psychotic thought of one kind or another and that appears to lead..eh..to ... you know...a breakdown in their functioning on a day to day basis a fundamental inability to communicate with peers or staff and there are other areas ... eh... that

Mo: Patient advocate is one of the important roles I think... you can take that role on board...I don't think we're always aware we're doing it.....I certainly do...making phone calls, appointments, all sorts of things on people's behalf.... you.... we're meant to know, we're meant to know everybody's...

Flo: Yes, we're meant to know everybody's resources eh... allowances ...yes, you'd be amazed at what we're expected to know.... So we're very much patient advocates and again relaying it at consultant's meetings and the doctor will say and what do the nurses think.. what's the nursing staff opinion on this so again you're relaying a nursing opinion to the medical staff. I think the patient sees us often... eh.. with the key worker system as their particular nurse and you're someone to talk to someone who'll listen to them if they've got a problem your the person who they can bring that problem to resolve it... so you're a counsellor...

Jo: Yeah, I think .. em..eh.. every day has been a different experience for me How could I put it.. eh.. it's been fantastic working in the long term ..eh..care setting because every day has been...has been like a different play..a different play every day..and never a dull moment. So you've got to put on different hats in accordance with which scene is being played on that dayy'know

Mo: Yeah...Sometimes we are custodians.....You may have to detain somebody under the nurse's holding power.. or detain somebody under the Mental Health Act. Your job is then to observe them to make sure they're still on the ward...to keep them on the ward if they're attempting to leave and then so.. you're looking at the priority being the patient's safety....that's your priority....to keep them safe.... so in that way you're taking over part of their personal responsibility to an extent you may be infringing on their rights but you're weighing it up all the time to do... you're weighing it up .. you're weighing it up every 24 hours if somebody's going onto obs...you're looking at it every hour.... do we still need to be doing this ?...because it is an infringement on their rights but you're always weighing up the patients safety I think that's an important part of the role because it is an infringement of their rights

Flo: You're their to educate as well and obviously you do this in the long stay as well, you know regarding obviously.... diet as well...we get a lot of peoplewith eating problems and things that come indrugs you know .. and What not....just to comply with medication.... so then we're educating them

Jo: Yea.... but no everyone's amenable to other forms of intervention or.. eh....education until they've had a therapeutic dose of medication in them. Well hopefully when you're..em..living part of your life with ...especially with long term.....they're in a longer period of time than they are in acute.. ..and they're spending a great deal of their lives with you and you with them...hopefully in that period of time you're going to influence in a positive way their mental state and their attitudes towards...towards life

Mo: Being therapeutic for me in the acute setting means... it has a lot to do with building a relationship with the client...that's the cornerstone of

it..you have to be able to do that. And that relationship is the thing that's therapeutic you know...that's what it's all built on....which isn't always easy in acute because as I say they come and go. In long term it must be really great because you can really build up a good relationship...I mean.. we could come in and do our first 72

hours.....go on days off and come back and that client's gone.....you know.....some of them you can have for a number of weeks and build up a really... quite a good rapport with them...em...it just depends

Flo: I think the general nurse may take a tray with a dressing on it to a bed... and that's their instrument of care....the instrument of care we have is very much ourselves in relationship to..... in our relationship with the client. All the different hats we wear..all these different things we do for them.. is based on that relationship and that is our equivalent to the sphig. or the dressing..... we're the transport for the person...it's our relationship with them...and the things that we do within that relationship ...that is.. that makes the difference for them and that's why it's really important that we know what we're doing and.... we take that responsibility seriously because every word you say to someone can have an effect on them so you've got to be ...

Mo: Because we're not actually doing things hands on we're seen sometimes as not doing anything...

Jo: But we're saying.. we're saying things hand on..if you like

Mo: because we're not actually applying a bandage or putting in a needle....or eh... doing things like that... you know.... they say...what is it do you do with them...

Jo: Is it important then for us to..eh..convey the importance of the therapeutic use of self to our

Mo: Mhmm..... conveying to them.. to let them know that you're always there for them if they need you.. and always making it a point.. it's .. you know it very difficult on this ward some days to come in and say more than 3 words to your client group as their key worker because you're just up to here with all sorts of other things..em...namely paperwork usually...and you're stuck in that office and you...and it can be very difficult to maintain that relationship throughout... you've got to fight really hard to... em.. to.. be there be available... convey... your availability...to be consistent

Flo: It also depends on the client as well... because you can have a very demanding client who constantly wants you all the time and forgets the fact that you've 'got another 3... em.... and some of them'll step back....well... thinking you know.. that person....she needs her a bit more than me so I'll just sit back and you find that that's the person who needs you more so again you've got to prioritise all that and the really demanding one probably doesn't need you at all

Jo: We see a lot of that too..just as well.... what you're talking about..yeah, yeah..

Mo: You have...you have to be very important of your own attitude... you're aware of the sort of messages your giving.. ..you know you get people in here with drug and alcohol problems, people who have been sexually abused, you get people in with all sorts of traumatic things quite apart from people who are clinical ..if you

like... and that is people who have schizophrenias, the manic depressives the anxiety states all these nicely diagnosed things...you get all sorts of other things as well which socially may not be terribly acceptable out there but we have to.... be aware that if we have any attitude with that..with their problem.....any problem dealing with that.....that we make sure we've got that well sorted out before you can go and do the job

Flo: You now ... it's there at the end of the day... because as you say there's no psychosis there you know you'll get the students and that coming in saying "what's wrong with that woman"...you know.."she looks all right what's she in here for ?" and you start to delve into her past and...you know.. they're totally shocked.. ..you know "God know wonder she's in here" you know.. because she's sitting and looks.. you know so called normal and enjoying a conversation with her fellow peers they think why is she in here

Interviewer

Q: What is unique and special and unique about your role as a mental health nurse ?

Mo: All the dimensions we have... I think general nursing... maybe I'm being a bit unkind to them.. but I see them being primarily concerned with the person's physical state.. em.. the relationship with the patient is secondary to that.... people come and go very fast in general hospitals these day's even with major surgery they don't have the time..or need at the end of the day to build up the same kind of relationship with the person as we do...em ... people have expectations when they go into a general hospital what's going to happen to them they go in it happens to them they go away again...it's not like that here..our our..our role is.. we look at people in a very holistic way.. we have to look at them in a far more holistic way because of the problems they have are not going to be as straight forward

Jo: I think maybe nursing specialities like general nursing they may medicalise things whereas we can't

Mo: I think we make a definite effort not to..not to medicalise

Jo: I feel quite privileged actually working with the client group that I work with..em..hopefully I'm doing eh..I'm able to influence the well-being... the mental state of the men that are in my care...em.. even just a little bit..it's you know it's well being able to get to know everyone as a person..em..everyone's interests and their own rights regardless of what experiences they've had in their lives whether they've been abused or whether they have been abusers.. and some of our men have you know have been both...em just being in a position to work with them work with their families, their carers and friends and relatives and hopefully doing something that's going to positively influence them in their lives

Interviewer

Q: How would you define mental health nursing?

LONG SILENCE

Flo: You obviously have to have a knowledge of psychiatric conditions...the ones you come across.. and that's the one's you get at college..you know the main one's that you come across..but actually once you get into the job you finds that there's a bit of a problem doing that. You need to know the importance of the therapeutic relationship and how to establish that. You need to know that you're the sort of person who can do that

Mo: You need to have clear communication skills. You couldn't come in if you couldn't communicate

Flo: You could but you just wouldn't get anywhere

Mo: No you still could do it but you couldn't get anywhere. It's about being able to draw things out of clients you know... but just.. you know.. I think being able to adapt really ...you're adapting constantly...to whatever client you've got at that time...as I say .. from the over demanding work that you've actually got to say back off a wee bit...you know..and as I say drawing out of the really withdrawn client.... .getting them..... again we can jump from a really quiet environment one minute and within 2 minutes We've got patients restrained on the floor..you know..fights going on.. em...it just...I don't know how you would say it...

Flo: I think most of what you need to Know is not something you can be taught in college

Mo: You can't..you can't ..no..

Jo: You were probably nurses before you came in to nursing

Flo: Probably

Jo: And the nursing college just developed it

Mo: I think for us age helps..and I would agree with that..I think the colleges are seeing that themselves aren't they..

Flo: Yeah...

Mo: You're having to ...I wouldn't have done this at 17..

Jo: No

Mo: I wouldn't have done it at 17. I think the fact that we've all got past lives...we've been there and done it..certain things..you know ...we can empathise with them...and you know it's easy to say you empathise with them but can you really ? because it's...

Flo: Feeling things with them...understanding exactly...

Mo: As best you can...as best you can...as best you can...as I say if you've had it happen to you then obviously it's easier...it helps 'cause you...it does.. you...you can relate...em...and if you can't it's just trying to relate as best you can...em ... that you accept what that person is saying...you know and that you are trying your hardest to understand what they are saying...

Jo: em.....I think I've always had the caring...what's the word...in me...em.. and when I went to the nursing college I have it developed..you know into another dimension...

It just took me 20 year to get round to doing it....you know to go into nursing...I'm so glad I did

Interviewer

Q: If it's difficult for you to define, give as good a description of mental health nursing as you can?

Mo: I think people think mental health nursing is difficult to define because they think we don't do anything

Flo: exactly

Mo: when you start trying to look at all the different things we do and then define that in simple terms its...

Jo: Should we have to define it ?

Flo: I think we do..we have to justify it..very much so

Jo: I think so... ..Aye.....maybe it's needs people going out and getting further education nurses who aren't educated need to get themselves educated.

Mo: I think people are more aware of it nowadays because obviously there's more a need of it nowadays...basically we were told to shut us and get on with But me people maybe say we're taking it too much to extremes you know... we're opening up all these boxes and should we allow them because....you know..because you used to talk about rape before but it never did me any harm but you know ... they're all speaking about it now and its in the papers...you know...and they're just making all this bother ...you know..em...

Jo: But to bring those issues out raises the profile of the... of what we're all about if we are to be professionals

Mo: It's what we're there for... yeah...I think it's not something college prepares you for...there's lots of things that college doesn't prepare you for and you step onto the ward not just as a newly qualified nurse... I would say once you get further on in your training and you start getting clients of your own and they just drop this bombshell on you...you know "I was raped by such and somebody" and you go. and you sit there and think ..well it all depends on what I say now... and you think bloody college never said anything about this you know.. and you sit there and you think..oh God..you know because it all fathoms on what you say...I mean..eh.. you can lose an client in the space of seconds...

Jo: and that's what's unique about the job

Mo: that is what it is

Jo: that's right

Flo: the chances are when your client already tells you that you've already built up a relationship with them.. that they trust you..and that you can get away with little mistakes because you've got this relationship. They're not looking for perfection from you, they're trusting you with this information and they're trusting that the reaction you will give will be a genuine one

Mo: but again that comes with the confidence of being a staff nurse...because that grows on you whereas I say initially as a student you just think "oh God if I say the wrong thing I've got to go back to the key worker and say "I've just ruined all you've done" so you say do you sit here and say nothing or no well you cannae just do

that...as I say you can only have a pause for so long... and it's just being able to act like that and again I say maturity goes for it

Jo: I've never been in the position where I've thought to myself.. you know.. what I'm about to say could ruin a whole lot of work...you know the relationship between patient and key worker...I've always known that what I was about to say was the right thing...because I spend plenty time with folk... but even you know....they might drop a bomb, well they wouldn't do that anyway..... not usually... sometimes yes..yeah.. not in this ward

Mo: In this ward yeah.. that's what I'm saying

Jo: Well.. in that case yeah I have had that as a student.. .. you know.... people dropping a real heavy number.. you know.. but I've dealt with it fine

Mo: I'm only saying this because I was twice on this ward as a student and I'm... I mean there's still people coming in here from when I was a student..... but initially you start off as the nice person who takes them out for walks.... and takes them up to the canteen and you're just there for them to chat to...you're not there for them to disclose things to and then all of a sudden they've built up this relationship with you and they just go wallop... like that to you... cos what I always did as a student... I never read their notes..cos I never liked to be judgmental I never....so when they then just threw this at you and you hadn't spoken to the key worker and you hadn't found all these things out that is what I meant by "oh God what do I do here"

Jo: Yeah.. but you deal with it in a confident

Mo: Yeah...you do ..you do.. I mean I've always... I've never ever walked away from a client and said, " oh God I've ruined that... I've said the wrong thing there" what I am saying is what goes on inside you and what is coming out of you is totally different... but again...

Jo: That's going back to wearing different hats on different days

Mo: Again that's mental health nursing.. that's ... I mean you can have your really aggressive patient and you're absolutely quivering inside but you stand your ground and you think if they could only see what's inside you...eh...eh... they look up to you as a person in authority and really you're thinking "ho..I got out of that one, wheow"

Flo: and I think as well that on a ward like this you find yourself in a situation you could find particularly difficult, with someone.... you've always got your colleagues to turn to and I think that's very important on a ward like this and I is a good team on this ward and you can turn to any of your colleagues and say look I'm a bit stuck here I don't know what to do here. I'm not suggesting its just us 'D' grades who would do this, I'm saying everybody does that..... everybody does it... everybody does it and I think that's extremely important no matter how long your experience is that whenever you do need help you can get it or need some support

Interviewer

Q: What specific knowledge and skills are required to fulfil your role(s)?

Flo: One of the best sources of knowledge and skills for students on the ward are role models on the ward. In the first few days on the ward.... you choose someone to work as your preceptor and who would be a good role model and you pick up from these individuals

Interviewer

Q: How do you develop the knowledge and skills required to meet your professional role requirements?

Flo: Through experience and through doing the same sort of thing

Jo: and they're the opinions that you formulate very quickly when you're in a ward even within maybe the first couple of days you know who you're going to look to for advice and guidance and support..

Mo: It works the other way as well...you know exactly who you do not want as a role model.. they're the one's .. you know.. I will definitely not do what she has done...

Interviewer

Q: What role does education and training have in the acquisition of knowledge and skills?

Mo: That's where you are linking all the theory you get to practice. In the first few months everybody has to do general nursing basically, and I think they should be looking at that because the amount of general nursing we did doesn't take you through... I mean we had a 'phone call yesterday.. there was two doctors on a ward here that couldn't put a naso-gastric tube down and they were asking us and I thought when was the last time we did that and you know and it's like everything else if you're not constantly doing it you forget it so you kind of think back and think " I did OK ". I did medical, surgical, orthopaedics I did the lot but what do I remember from it and at the end of the day you think was it worth doing it .. should they maybe not even cut it.. you know even down to the year giving you your two years to specialise in what you want to do, I mean throwing in everything you have to have....like the midwifery because of the UKCC, but at the end of the day what have you gained out of it

Flo: Well I think you didn't get enough information about physical problems...em..if you look at a ward like this you've got people coming in with asthma and...

Mo: Well yeah.. in this ward you do here

Flo: all sorts of physical problems and we're just not equipped to deal with them as project 2000 nurses

Jo: I didn't think I was even equipped to sit my half way exam..you know..

Mo: but if that's the case, they should either be extending it or make it you all to you three years general and then specialise

Jo: the only back we've got for patients with physical problems is a GP... a ward GP who makes an appearance

Mo: Yeah.. we have a ward doctor too and he can prescribe and then we give the medication to the patient, but I'm sure we don't all know what we're doing here.. Psyche medication yeah, we all know that but physical no

Interviewer

Q: Is there any other way in which you have gained knowledge and skills necessary for your role ?

Flo: You learn these skills in a structured way, passed on to you by others

Mo: I think you learn that before you come out, its a behavioural.....

Jo: It's imparted on you by other.....

Flo: Professionalism is a behavioural think, you behave like a professional, I don't consider myself to be a different person no than I was the first day as a student

Flo: It's a type of behaviour

Mo: The way you conduct yourself

Flo: Right down to the way you dress and that but again...

Mo: It's just all encompassing your role... I don't think it's something that you pull out and learn the way you learn about schizophrenia.....they way you learn about... and I don't think it clicks with you one day that you've learned it but you are it.. it's what you're doing every day. It's another thing you're taking from other people when you're on the wards and you're seeing these people a behaviour that your learning

Flo: And again, as I say..... you avoid the one's that you know... you think... you know I'll never act in that way.. you know... I'll never do something that way

Mo: I suppose as a student you must have had some kind of knowledge as a person to know that this person was not doing that right

Flo: That's back to the value and the way you've been brought up.... and you see things from there

Interviewer:

Q: OK, we're coming to the end of this interview, are there any other aspects of this topic which you feel have not been covered and would like to raise?

Jo: I think it's true that not everybody's got what it takes to be a good psychiatric nurse as carer.. yeah

Mo: You either sink or swim sometimes

Flo: That often depends on the ward you go to and we're really really lucky on this ward

Interviewer

If that's all, I would like to thank you for participating and for giving me some of your valuable time

Focus Group II
PhD focus groups 1998
Registered first level mental health nurses
3 from forensic mental health
2 from rehabilitation and resettlement areas
2 from community

Interviewer

Q: Describe what you do as mental health nurses in your own area of practice?

Paul 'Well, I'm a community mental health nurse working in Dundee, specifically with people with severe and enduring mental health problems, focusing on rehabilitation em... basically that's it..that's a kick off'

Sue 'I work in the same department as Paul, but..I..work in the which has it's good points and bad points'

Saul 'I work for Fife Health Care, working between hospital and the community and I'm ward sort of based em... rehab. sector em.. trying to enable people to move on into the community base em..not an easy job at times but eh.. it gets there'

Prue 'I work as a team leader in Ailsa hospital in Ayrshire, and I don't really have any direct patient contact, which is one of the reasons I'm doing this course actually so that I can... I can get one back em..and . it's mostly sort of managerial support for charge nurses.....in the wards...and that's in continuing care, rehab. and resettlement service'

Lu 'I work in a day hospital, I work for Perth and Kinross and.. I work with..in each group eighteen upwards..but we don't eh.. have anybody with organic disorder... mainly function'

Col 'Eh..I'm the manager of a six bedded rehab. unit..eh which was started off two and a half years ago..eh..so in effect it's been my baby which might sound paternalistic but eh..I was the manager and with the staff I've got there I really..expanded it in a way that wasn't always going down that well with other people. We've attempted to provide care and the so the clients that we've had we've continued involvement with them and we will for example go and give them... eh there's three or four that actually receive injections, so we go and give those which, has caused a bit of problems to some people..so..that's basically it'

Saul 'I think a lot of frustration builds up within the rehab network due to the fact, I mean I discussed a while ago with a new manager that started with the social work, I phoned up and said what about these people that's blocking beds and he said well it's not block beds it's block people, he says these people are ready at the door with their bags ready to move on butin the community are not ready to take them on, so what you do is you bring these people back, back a step from the door and you try to maintain them so they're waiting on the sideline just for a place to move on, you know and if it doesn't happen it's quite...'

Lu 'And what's frustrating about that then, I work in a day hospital and we have the opposite side of the coin where we have people who are desperately needing to go through or unfortunately are needing to be kept within a safe environment and we cannae get them in and they're on a waiting list to the point sometimes where, I mean we have one chap who I monitor about going to Tesco's at five thirty every night to check he's eating because when he becomes really unwell he won't eat, he thinks his foods poison and that'll be the only way I'll know I have to start bringing bigger ..in it'll not be till he's that bad, that he'll eventually get pushed through the system, because there's no beds..if I know he's going to Tesco's you know..'

Paul 'I feel quite fortunate in the job...nursing role that I have, it's very similar to what I believe Gordon is doing in his environment except I feel quite fortunate that I can do that work in that client's own environment and I can provide a more intensive service I can spend a whole day with a particular client if I wanted...'

Interviewer

Q: Tell me about the role(s) you undertake in your work as a mental health nurse?

Prue 'I think my job is to facilitate things it's to...it's...I'm there as a support for people in terms of what they do in their practice and any problems or difficulties they have and I.. you know it's a talking job that's what I do and it's mainly staff I talk to, just to facilitate them with any ideas they have, I'll help them see it through, that's my role, it's also a lot of the other management stuff that you get landed with, all the stuff that nobody wants like disciplines and sickness and absence and stuff like that, there's lots of that'

Saul 'I don't mean this in a negative way, but do you still see yourself as a nurse, because of the managerial...?'

Prue 'I do, I mean when I took the post em I..I could see room for there being a clinical part to it, but it didn't turn out that way I became..I suddenly had nine wards, that wasn't..there was only originally meant to

be six wards for continuing care, rehab and resettlement, but I got acute wards too, so I got bowed down or bogged down by the issues that came up, but I do..yes I'm still a nurse, although I don't see them on a therapeutic..well it depends on your definition of therapeutic...I see more people every day but it's very small and I wouldn't say I'm having therapeutic relationships...'

Saul 'Because I think..well, looking at the role of a nurse they're going to have direct client/patient contact, they're going to be working either one to one or in groups and you're role is either different from the rest of people that are in the group'

Sue 'An educator'

Prue 'A provider in some cases as well you're providing maybe the likes of company often than not but you're maybe like the provider of friendship to someone, provider of communication, the provider of information and knowledge that this person maybe doesn't have or doesn't have the confidence to go and find it, so you're the provider of..you know..maybe certain deficits that this person has in their...'

Saul Security as well I think's a big one

Prue Yes, yes, you're providing security for them as well, in the sense that you're there, they know that you're there, they can rely on you and they can trust you'

Col 'We used to have a conversation, before I took on my present role I was a senior staff nurse in acute psychiatry, and eh... ah... I had spoken to my wife who works in acute psychiatry as a charge nurse and has done a degree course and the actual way that treatment is actually really implemented it hasn't changed and it's like we talked about ten fifteen years ago and I'm sure if you walked into an acute ward say today I'm sure it would be, the patient comes into hospital, they're seen by a nurse, there's some sort of talk, if you want to describe it as being some sort of counselling therapy, but I think that point you made at the start of.. eh well you've got folk that are trained for two or three years and it's as though it hasn't changed, folk may still come in they may get ECT or they may get sort of drug therapy, but apart from that, I don't really know what's changed I can only speak about my place of work and that is to try to get people away from the idea of being in the role of the patient, which is extremely difficult because we are in a hospital site and I do feel very strongly that people come with particular baggage of I'm a patient, although they are not described in that term, they're in hospital and you are a nurse and I expect you to behave in particular ways and I'm, I suppose, with the job I've got now, I think it's only when you take on, if you like, a charge nurse role if you want to describe it as that, that it is really quite different and you had spoken about these things of you've got

sort of personnel issues eh..and the issues of discipline, if you want to describe it in that term, you've got to try to deal with all those things that are going on and I sometimes wonder yeah I did train to be a nurse but it's as though it's in the past and I tend to lose sight of that, because although I've got contact with the client group each day, I'm so tied up with meetings, paperwork that I sometimes actually forget that I trained to be a nurse'

Lu 'That I think..where I work is a very, very small unit in there's only eight nurses em..we're not part of a big hospital either, we're an old house that's been renovated and the difference I would say is ..maybe it's because we're quite close em..you know we get on well a lot of the management role is distributed quite evenly between us though we still have a very clear hierarchy, well ther'e only one that's higher than us em...I would maybe think then that our manager you know would be different from you that he still has his own caseload, we work autonomous as well so we have to make a lot of management decisions for ourself em... where we don't have somebody else to turn round and maybe ask'

Sue 'Do you think our job has maybe changed in that respect that we are slightly more autonomous, because I came from a very...'

Prue 'I trained the old training....we were talking about this this morning and coming back through the P 2000, oh..huge difference absolutely enormous, I remember the last time I mean I still get mocked for this at work, a doctor walks in..we have a consultant just now that does intimidate me, and she'll walk in and my heels click and my shoulders are back and I notice students who are very good and they're not inappropriate, but I've noticed that they're much more relaxed than I am, but I think that's the old medical...'

Sue 'Is that not a positive thing that we've actually...'

Lu 'Very, don't get me wrong...'

Sue '...the horrific hierarchical structure and...'

Lu 'I enjoy having the knowledge now to be able to challenge, I think that was the one thing that I felt I lacked..'

Sue 'Five years ago you didn't even challenge when you think about it whereas now because we are more autonomous, because the change in the circumstances we are working for our patients out there we have got be more autonomous, make more decisions be much more stronger for our clients, be that likes of an advocate for our clients and we are actually adopting that

Lu get a junior doctor who has just come in as an SHO and is just about to do his first you know proper psychiatric placement and I think that's when you get the confidence that's when you realise that...'

Paul 'Do you not just think that we're just recognising this more we've actually been doing it all the time it's just that we're actually sitting and looking at our ability..'

Sue 'No, I think we're actually putting skills into practice, I think over the last, well I've been working for ten years and Lu you were twenty three years ago, and likes as a junior staff nurse

Col 'Yeah I..I don't think I knew what that actually meant'

Joss 'I came in to care for people, to help people and I still see my role being very much a caring role, I still see my role being a nurse even though I might take on other responsibilities such as therapist, group facilitator em..meeting co-ordinator, CPA co-ordinator em..all those different roles..'

Lu 'That's nursing, I would argue that that is nursing'

Sue 'Well part of the job of nursing'

Lu 'If you're a group facilitator, you're caring you're..you're providing care'

Joss 'But I think your views when you first come in are narrower than that, they widen out as you get more experience, certainly my role is very different from my role when I was a staff nurse on the ward and now that I'm a staff nurse in a psychiatric day hospital it's very different and you are very much more autonomous the difference is you're expected to..eh..make decisions yourself, make clinical decisions yourself..em..you make up a client's programme for them while they're attending the day hospital, which you aren't expected to do when you're a staff nurse at the same grade in the ward, you're expected to do make these assessments, do an assessment on somebody, send that out to the GP so the GP's aware, everybody's aware of what your assessment is and how you get to that criteria for assessment using a research base assessment tool, now when I worked as a staff nurse on the ward I didn't have a clue, or maybe I should have had a clue, what a research base assessment tool was, you know you had your own kind of assessment criteria, whether it's the nursing process or Roper, Logan and Tierney, but certainly working in day hospital and developing these assessment tools and using these em..and working as part of a disciplinary team you're much more autonomous and equate yourselves alongside the psychiatrists and the OT's who all work separately, but as part of a multidisciplinary team'

Lu 'The biggest surprise I got when I was being shown the admission procedure and I remember saying to the nurse, right do that, that, that, the usual, ten twenty forms to fill out and I says when do they see the doctor, because I was automatically thinking acute ward, and you know the procedure in there, you know the nurse does her bit and immediately after the doctor, and I just got a look and a laugh and they just walked away and you know we don't have medical staff within Weston either unless we call them down or they're down for specific meetings and I found that was

Paul 'I got the impression that I've been full circle, I've been obviously clinical in a hospital base and then been to the day hospital but I've started going back again to the hospital and seeing the transition, you know sort of going up to... and I think the caring role in the day hospital was possibly seen to be more of a caring role because you allowed the person to be an individual and you supported the..the deficits, in the hospital base you..or the tendency of the older school is that you support everything to make sure that everything goes according to plan, they bath and they eat and all those sorts of things rather than the person as an individual'

Interviewer

Q: What exactly is unique or special about your role(s) as a mental health nurse?

Prue 'The system and the routine...yeah, yeah, the individual system that you're facilitating letting them grow, letting them take challenges, taking..no controlled risks and letting them trying something knew the hospital bases are so...'

Lu 'I think every night they go home and it's the one main philosophy in Weston is to maintain people within a community setting to get them well, you know and if possible and sometimes it takes a lot of hard work to keep them out of acute, you know em....'

Joss 'I would just say the difference very much between the ward based and community based is the kind of relationship you build up with your patient or client, it's you the person sees all the time whereas the ward based patient knows that there's somebody else coming along to cover the back shift or whatever and it's maybe a bit different in Saul's ward, but we cultivate this relationship with our patients and they perhaps don't know the rest of the nursing team or the medical team because we're the only person to see them and that's why we are much more autonomous in this area, certainly you know in the community also we are much more autonomous practitioners'

trying to decompartmentalise staff, because, we've spoken about this before, that I think it's archaic that there are people that who will only work in a hospital setting and people who will only work in a community setting, I, because of the job I've got, it is really quite logical to expect that people make that transition out to being in home and you will take people shopping and you will take them to the cinema, they'll go to the pub etc., etc. so to just look at the role of the nurse with regard to the job that I do, you don't have a ward based role, so if you like you've got a role that's between the traditional ward based nurse and a CPN ... has a lot of interesting possibilities and you know, and I don't want to say well, that's what I do, I work with the acutely mentally ill only, I mean we will have people who can be described as being acutely ill, you know I think you've got to get away from, that's my role, that's my job description and I can't expand on that, because there's a lot of good literature coming out about and we're all quite clear about the 'expandable the nurse' well, that's what I've been doing, I've been saying to people well we will go and give 'decos' but you've got some folk who will say 'that's great that will make my work load a bit easier' but you've got other CPN's that are saying, no'

Paul Protecting their role'

Col 'But, I do make quite clear to people that we are not CPN's....but to get back to the question of what we do, I think that's always like eh... the quest for the Holy Grail, because we can't, I don't know it's like... eh... it used to be a job that people would go into when, it was there, I mean it was a joke at the hospital I used to work in Inverness that 'could you play football, well you can start on Monday', but we don't want to go back with that'

Paul 'Do you think we've answered the question, what is unique or special about our role, because I don't know if we have, you know, I think what everybody is saying is that we're very flexible and does that not make our role very nebulous and undefinable em... I think...'

Paul 'It could also be a weakness though... Because then you are more liable to be working in so many different areas that you are just chasing your tail all the time. If other specialities in nursing are very specific in what they will and will not do and they get recognition for that, whereas in psychiatry we don't have the specialities then you know, this is a psychiatric patient and you look after him kind of thing and you follow them about from ward to community, I think we do need to have specialities within psychiatry'

Lu 'Do you not think that's happening, now with people becoming more specialist in say just off the top of my head em..someone may go and study cognitive therapy and then, we were speaking about this with the CPN's, and rather than a person just being allocated an area,

they're allocated people then eh... now we worked like that in the hospital, say for example I do the anger management, so I will then take the referrals, and like I enjoy working with people with dual diagnosis, so I have an interest in study on that, so then if referrals come in for people with dual diagnosis, I tend to... so I think, I know it's not as structured as say a general em..a surgical nurse or a medical nurse, but... it's happening'

Interviewer

Q: What specific knowledge and skills are required to fulfil your role(s)?

Lu 'Everything there is to be known, in that, say it's a chosen area em...continual development, continual study..'

Saul 'I think you need to be a good communicator. It's like the old system years ago when people went into a maybe an engineering sector and they got their apprenticeship and went through all the different departments and they picked all the wee bits of information and they specialised, unfortunately mental health nursing does to a degree, and a lot of the hospitals have stated that, it's never moved it's got all the wee bits of information, but nobody wants to put a specialist area, and that's kind of sad, I mean I found going into the rehab and working in other areas, coming in and saying 'I want to look at that, I would like to do this' people started to point out that that's your bit you take on this' and that was good and if everybody could do the same thing then I think the system could improve quite considerably'

Saul 'I see more and more of us working in a specialist area who work in the job that I do, intensive nursing service to enduring mentally ill people in Dundee eh... in their own homes and there's no many people that I know of, or teams in Scotland who do actually provide that service'

Interviewer

Q: How do you develop the knowledge and skills required to meet your professional role requirements?

Saul 'I think you need, personally for myself I need to feel that I've got a competent level of knowledge about what I should go out looking for and the actual skills I should be practising with that person, that I should have good assessment skills, because of you go out and you can't assess somebody's deficits and capabilities, then it's a waste of time, so I feel you have to have a really good, sound knowledge, a local knowledge as well, you need to have awareness of local services and not only just utilising you own skills but bringing in other people as well and knowing how to do that networking with other people eh... promoting your own service, going out and saying to people 'this is the job that I do', part of the

reason is to network with other people and find out about their service and tell them about mine, so you know, to me that's a skill if I can go out and do that'

Paul 'Group work skills, em..teaching..teaching skills, both on a one to one basis perhaps with students, patients carers em...just general kind of communication skills and I think we do build these up as you practice from being a student to being a practitioner we build up communication skills, but sometimes I think we perhaps get them wrong from the start, you know and I think sometimes we really need to em..kind of evaluate our communication skills and our practice as we go along'

Saul 'I think psychiatric nurses as well as looking at other people have got to be able to themselves as nurses, like, 'what's my strengths, what's my weaknesses' like you know being honest and we're not very good at that and 'I'll do that and I'll take that on' and maybe not making a very good job of it and maybe someone else could fill that role better'

Lu 'I think in Weston one of the things is, again going back to the fact that there's not a doctor there, you know we don't necessarily always need one, and it's recognising symptoms and that was one thing that I had a problem with when I came in because it may be because if you don't recognise that his person is seriously suicidal and you close the doors at five o'clock and go away home..yes .. em...and it was the one thing that I found that the other nurses that I worked with had gained through experience and wasn't really perhaps a viable tool there that you know...'

Saul 'You're quite fortunate in Weston in view of the fact you can challenge and he was willing to listen and he made you, he empowered you to take decisions and he supported you and that network kind of built up, and that's good'

Lu 'I didn't have a problem have a problem at first as a nurse as to whether these decisions were mine to make and em..I eventually when my confidence was at a point and I was thinking I'm not making this decision and I would phone a doctor and get them down and that's... it can often be a battle for ours, because I think in Weston the doctors do depend on us a lot and have a lot of confidence in us, so when you want them down sometimes ... so it's difficult, but I suppose the advocacy there, you're you know...'

Joss '... sometimes we do need to say, no I've done as much as I can here and I need to bring in another member of the team...'

Lu 'Yes, I mean I've had a GP say to me, because if the person has gone away home and I'm really, really concerned and I've had to call

and the GP'll say 'you're passing the buck', em..well, perhaps that's what I'm doing but as a nurse, I'm sorry but I don't feel it is my job, I can't go out there and say to the person 'I'm taking you into hospital do you want to go or not'

Sue 'Can that however not be seen as a bad move as well, cause here's us sitting here discussing what our roles are today and what we need to fulfil them, but what about the other professionals GP's if we don't know what they are..'

Lu 'Oh, yes I know what you're saying but they have the responsibility we don't....'

Sue '...but they ultimately do I'm not taking that away, but that's something they need to be aware of, we need to be aware of our own roles...'

Paul 'Could I just say I think our roles and skills are quite a personal thing to us, they're doesn't seem to be the same uniformity to the skills that we learn and practice, you know you mentioned anger management, but you maybe do it a different way than what I do it because if you're in a more sort of adult nursing, general nursing, if you're dealing with a fracture or whatever, there is more uniformed way of dealing with that I think that's where psychiatric nursing is a wee bit different, is that you know the skills that we learn are quite personal thing to us and you try and develop those skills to suit your abilities rather than...there's various..vicarious ways.. you learn from other people, you watch them and you also do, that's why we're here today is to learn skills from teaching establishments or attending conferences courses that sort of thing em...'

Saul 'But you get it back from your clients...'

All 'Yes, that's right'

Saul 'When I ran the relaxation management, anxiety management for such a long time and the feedback made me develop my presentation, improve with the feedback I got from there..and that's so important'

Prue 'I think... last week as well when we were saying what was the good changes and the bad changes in the NHS and I think our group had spoken about we tell patients things now and we give them information and they give us back, you know, what they want from our services, which wasn't there before'

Joss 'I think I got mine from working in the area that actually I'm in and I have done for just four years now em.. and a lot of that knowledge came

from a vast range of nursing experience and having the opportunity to go into various different kinds of groups, an opportunity to go into people's individual sections and they were very open to new staff doing and not kind of saying no you can't come in to this session because I don't think the patient would like it but, you know, saying to the patient 'is it OK if a new staff nurse comes in' and learning from other people's experience, but also having that experience updated on a regular basis, research based, you know, is something we're all told to do, look at the research, is your practice still relevant, is it still up to date, and making sure that we are following kind of relevant practice, not jumping on bandwagons or anything like that, but you know looking at what's happening in other areas, is it successful, is this something that we should be doing, you know should we try and do this on a pilot study basis to see if it's something we should be implementing in our own area, so I mean part of it learning from other people's experience and part of it is research based and also from the other disciplines as well, getting prompts from them you know and if you're doing a joint session with somebody, saying perhaps you should have dealt with it in this way or I would have perhaps done it differently and that gives you guidelines for the future'

Interviewer

If there are no other aspects of this topic that you feel have not been covered, we will stop here.

Thank you for your time

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